UTILIZING EXISTING
HEALTH DATA SYSTEMS
TO DEMONSTRATE A MODEL
FOR EPSDT PLANNING/EVAL

#322

Roosevelt Hospital 425 West 59 Street, New York, N.Y. 10019 212/554-7000

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UTILIZING EXISTING HEALTH DATA SYSTEMS TO DEMONSTRATE A MODEL FOR EPSDT PLANNING AND EVALUATION

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FINAL REPORT

PREPARED FOR

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112 STATE STREET
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ALBANY, NEW YORK 12207

Information Resource Center

EPSDT 6.71

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I: INTRODUCTION

The present research and demonstration grant was an integral part of the development of an evaluation model for EPSDT, the Medicaid child health program. The effort was undertaken to demonstrate the viability of a Federal evaluation strategy predicated on the improvement of data systems presently in operation at State and local levels. It was part of a study contrasting the feasibility of augmenting local data systems with that of mandating a Federal evaluation system.

Federal evaluation efforts historically have been fraught with failure. Typically, such programs require States and local projects to provide data to meet exacting prescriptions which it is expected would culminate in common reporting systems across projects. These efforts have rarely, if ever, been successful. The problems are particularly acute in Medicaid funded programs insofar as the Federal health financing efforts have taken the form of supplements requiring States and, in some cases, local areas to provide matching funds. A concomitant of the shared fiscal responsibility is State and local individual authority over program operations.

The result of independent authority in EPSDT has been widespread variation in program implementation. Of particular importance is the degree

to which State and local projects have developed different support systems to meet their needs, especially systems which provide data describing program operations. To mandate a Federal evaluation system would conflict with these existing systems, since in many cases local information user needs are different from Federal information needs. Consequently, the result would frequently be the maintenance of two disparate systems, to the detriment of Federally mandated ones.

To overcome these problems, one approach which has been suggested is to improve local systems so that both local user needs and Federal reporting requirements might be satisfied. A State and local project were each requested to submit proposals to demonstrate such an attempt, Roosevelt Hospital being the local project.

The proposal submitted by Roosevelt Hospital called for a demonstration in which existing health data systems would be utilized to meet State and local reporting requirements, in particular those needed for evaluation and planning. In meeting these objectives, Roosevelt Hospital has improved its own planning and evaluation while developing a capability of meeting State and Federal reporting requirements. This latter effort consisted of reporting CHAP data (New York State EPSDT program) to the city (and State) as well as meeting Title V (BCHS) demands, without necessitating the addition of new forms or additional data to be collected at the hospital.

II: BACKGROUND

A. ROOSEVELT HOSPITAL

For many years Roosevelt Hospital has been a major provider of health care to Manhattan's West Side population. A voluntary, non-profit institution, Roosevelt serves a catchment area consisting of some 10 Health Districts of the Borough of Manhattan covering over 400 city blocks. This area is bordered by 6th Avenue on the east and the Hudson River on the west, between W. 38th and W. 94th Streets.

The Hospital provides a comprehensive array of in-patient and out-patient services both to residents of its immediate catchment area and to a smaller but significant population of New York and New Jersey residents generally. Physician services are provided both by house staff and private practitioners with hospital privileges. A significant proportion of the institution's energies are devoted to teaching and research, and the institution is a major teaching affiliate of the College of Physicians and Surgeons of Columbia University.

By comparison with national norms, Roosevelt is a large institution. Since 1967 it has maintained a bed capacity of 595, with annual admissions running well over 20,000. More importantly for this project,

the Hospital has maintained a steady trend of increasing availability of ambulatory and emergency services to its target population.

The Roosevelt Hospital Pediatric Service is comprised of a broad array of in- and out-patient health and health related services as well as teaching and research programs organized according to a philosophy that all children are entitled to health services which are continuous, comprehensive, humane, and reflective of the current state of medical knowledge. Basic facilities consist of 40 pediatric beds (average patient occupancy about 15), delivery services (1,875 newborns in 1974 with an excessive number at high risk due to poverty, adolescent pregnancy, and addiction), emergency services (provided through the hospital emergency room), and a coordinated program of comprehensive outpatient services (currently some 40,000 annual visits).

The outpatient services, of most direct interest to this demonstration, are provided by multidisciplinary teams with catchment area families assigned to teams by neighborhood. These services are provided primarily in a large pediatric clinic located at the Hospital's main address.

A Title V BCHS Children and Youth Program (C&Y) provider since 1967, Roosevelt attempts to introduce all children utilizing the clinic into a program of comprehensive care. Children brought to the clinic for episodic treatment, or referrals, are scheduled for a detailed health

assessment which far exceeds current New York State Child Health Assurance Program (CHAP) EPSDT requirements. An automated scheduling system provides a basis for determining no-shows and identifies subsequent follow-up needs.

Problems encountered in health assessment are treated (and recorded) at the time of assessment, or scheduled for more intensive treatment at a later date. Once problems are ameliorated, periodic reassessment is automatically rescheduled using the automated scheduling system. There are currently 11,823 children actively in this C&Y system. Children referred or presented for care who reside outside of the catchment area are scheduled for episodic care requirements using the C&Y scheduling system. However, they are not tracked actively for completion of health assessment and periodic reassessment. There are currently some 6,000 such patients using Roosevelt services.

Roosevelt also became a CHAP provider through agreement with the City of New York. Under this agreement Roosevelt is required to schedule and screen no less than 100 children per month. Lists for scheduling will be provided by the city whose social service staffs are responsible for screening notification and outreach efforts. Roosevelt retains responsibility for treatment scheduling and follow-up, and rescreening as necessary. Important in this regard, given the large number of

children actively involved in C&Y, is a city agreement to reimburse Roosevelt $5.00 for a determination of equivalence for its current service population. Equivalence is determined by an automated review of hospital data systems to determine if CHAP screening requirements have been recently met.

It is important to note that while the primary focus of pediatric care is on introduction and maintenance of children in a system of comprehensive health care (with services offered through hospital based facilities), the Pediatric Service is simultaneously a teaching and research center.

The Service develops and operates a series of experiements in delivery of pediatric services, as well as basic research programs. Service delivery experiments include adolescent outreach, free standing drug therapeutic "communities," special screening and ambulatory care delivery in day care, nursery, preschool and public schools, health education demonstrations, and experiments in child development.

The importance of this broad and aggressive program of experimentation, in terms of this demonstration, is that the planning and evaluation system developed must, and will, provide an information basis which allows the relative effectiveness and efficiency of such experiments to be determined as opposed to more traditional service delivery forms.

B. EXISTING PEDIATRIC INFORMATION

The Roosevelt Pediatric Service independently and in consort with the general hospital, has evolved a set of information systems reflecting perceptions of management requirements and demands for data by external actors.

The first set of data to be developed were hardcopy files reflecting standards and internal hospital demands for medical and financial information. These data include information on costs of service operation, as well as standard medical records.

Upon its selection as a C&Y provider, Roosevelt was required to implement an additional system for C&Y reporting. This system includes scheduling, diagnostic, and disposition data, and has been routinely put in machine readable form.

The pediatric service did not find the C&Y system to be reflective of its own needs and interests. Thus while continuing to operate this system by requiring staff to complete necessary forms conscientiously, it developed an automated system focusing on the immediate concerns of scheduling, billing, and obtaining status reports on children in the health care process (e.g., no-shows). This system, maintained by

an outside source (Meditech), currently provides much of the data required for management of the Pediatric Service. The following sections detail information available.

Pediatric Clinical Record

A clinical record is maintained for each patient in hardcopy. The record is stored in the medical records section of the hospital. It is routinely requisitioned to be available for scheduled appointments. It contains the following categories of information:

a) Registration information including patient, family, personal data, and insurance information, is supplied on the Out-Patient Registration Form and the Declaration of Family Income and Size Form.

b) Patient history has four associated forms: (1) Pediatric Clinic History which contains data relating to birth and feeding, immunizations, family medical history, and previous and present illnesses. Previous medical care, specific immunization records, and development and behavior are compiled on (2) Vital Data Sheet--Medical History. Specific nutrition evaluation and natal history are recorded on the (3) Dental, Nutrition

and Birth History Form. Also retained is the (4) Parental Assessment of Child's Health.

c) Medical evaluation is maintained on six forms: (1) the Review of Systems and Physical Examination Form details medical assessments, initial diagnosis, and immediate treatment plans. A conference sheet which includes final diagnosis, continuous treatment plan, and actions taken is attached to the Review of Systems and Physical Examination Form. The (2) Problem List and (3) Medication List provide a continuous record of patient history. Vision screening results are reported on (4) Vision Tests for Preschool Form or (5) Vision Test for School Age Children Form. The (6) Recall Assessment Record is utilized for periodic assessment and includes data on illnesses, injuries, and hospitalization which occurred since the previous assessment, in addition to comprehensive physical examination data.

d) The Dental Record Form contains history, treatment records, and the results of Orthodontic Clinic examinations. A laboratory history is maintained through inclusion of all laboratory results.

In addition, a Release of Information and Consent forms are stored in the Clinical Record Folder.

THE C&Y REPORTING SYSTEM

The C&Y reporting system was developed by Minnesota Systems, Inc. under Federal contract for the purpose of putting in place a uniform statistical reporting system for C&Y projects. The system was implemented at 54 different projects. The results of the last few years have indicated that reporting of many projects was frequently fragmentary and unreliable. The Roosevelt Hospital C&Y project, however, was identified as one of the most conscientious of the projects in preparing their reports and as a consequence still continues to maintain their records.

While the data collected for reporting provides a comprehensive patient history, it has never been used for individual patient or local ambulatory care planning and evaluation. The data is collected, key punched, and transferred to tape. Subsequently, a series of analytical routines prepared by Minnesota Systems which provide gross summary reports are carried out.

The particular reports have not been considered useful by program administrators. However, recognition of the eventual value of the detailed patient information has led them to continue to collect this data with the hope of addressing it. Information which is

contained on the data tape files has allowed for identification of screening equivalence to CHAP and also, as the data is routinely collected, it serves as the basis for automated preparation of CHAP reports.

Following is a brief description of the data contained in the forms which are key punched and maintained on tape.

a) Contact Form I--Patient Registration contains patient and family personal data and comprises a file called the C&Y master file.

b) The transaction file contains patient records from the following three sources: Contact Form III--Medical, Psychiatric supplies the initial assessment, diagnostic codes, laboratory tests ordered, referrals, immunization, and a reappointment schedule; Contact Form IV--Other Areas is utilized for non-pediatric visit information, such as psychology, speech and hearing, nutrition, social services, and nursing; Contact Form V--Dental provides data on initial assessment care status, type of treatment, and x-rays.

PEDIATRIC SCHEDULING AND BILLING SYSTEMS

An outside contractor, Meditech, presently operates various computer systems which support pediatric ambulatory care. In particular, they provide scheduling and billing services.

Their systems consist of four main routines which may be described as follows:

(1) An appointments routine which is used to schedule patients within the restraints of staff availability. This routine sets up an appointment file available for reference to other routines.

(2) A "Census" routine which contains patient registration information. Output options available include patient data display, appointment history, and population counts.

(3) A "Maintenance" routine which performs options and look-up required for billing functions and staff scheduling.

(4) A "Reports" routine which includes all hardcopy reports and listings produced. Available options are daily appointment lists, acknowledgement of appointments (which is used to identify no-shows), billing lists, and other statistical reports as requested.

OTHER HOSPITAL DATA SYSTEMS

In addition to data systems specific to ambulatory pediatric services, Roosevelt Hospital maintains ongoing fiscal and management data systems. These data systems are capable of providing detailed information about a variety of services supporting pediatric care and their costs.

III: REVIEW OF EFFORTS

Efforts during the course of this grant were directed to demonstrating the ability of existing data systems to meet Federal reporting requirements. Concomitantly, efforts were undertaken to improve the quality of the existing files to meet local user needs.

As a result, Roosevelt Hospital developed an automatic reporting capability which presently prepares reports to New York City in accordance with CHAP reporting requirements and to New York State in accordance with BCHS Common Reporting requirements. In addition, a series of evaluation reports for local use have been developed and work was also directed to the specification of information requirements necessary to operating an efficient pediatric ambulatory clinic. This latter effort is part of an ongoing hospital interest in minimizing data collection while at the same time improving their ability to provide health care services.

The following sections provide detailed documentation of the work undertaken during this grant.

AUTOMATED REPORTING

Roosevelt Hospital, at the conception of this grant, was in the process of negotiating with New York City to become a CHAP

provider. The New York City CHAP program is interesting insofar as it recognizes institutions providing equivalent health care services. When they become CHAP providers these institutions are requested to identify those patients that are Medicaid eligible and who have had an assessment and required treatment during the preceding 12-month period. For children the institution reports as receiving equivalent care, a $5 reimbursement is provided by the CHAP program. For new children referred by the CHAP program, the assessment fee is $35, while any subsequent treatment fees are reimbursed at the regular Medicaid rate.

Consequently, an institution such as Roosevelt Hospital stands to lose the difference between the CHAP assessment fee and their regular Medicaid* reimbursement amount for each new CHAP-referred registrant assessed. Many institutions in the city recognizing the potential loss of revenue have chosen not to enter the CHAP program. Among the factors that entered into the Roosevelt Hospital decision to become a CHAP provider was the potential award of this grant since the grant would permit development of a system for automated review of records to determine children who had received CHAP equivalent services and hence to obtain the $5 reimbursement fee. The grant was also expected to be used to develop a method to prepare an automated report for new CHAP registrants which in turn

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*At the time of the CHAP contract, Roosevelt Hospital received a Medicaid reimbursement of $51.42 for each child visit.

would not require an additional burden on service providers. Consequently, coincidental with the application for this grant, Roosevelt Hospital agreed to become a CHAP provider.

The CHAP reporting and billing system consists of three forms:

(1) W-294A: Child Health Care Status Report (for children already receiving care at the providing institution)

(2) W-294B: Periodic Child Health Examination Report and Claim (for use with CHAP-referred new registrants at the providing institution)

(3) W-294C: Summary Claim Form for W-294A clients (this is a summary billing form prepared in batches of 25 children for whom W-294A status reports have been prepared)

To develop these reports a complete analysis of the existing data systems is undertaken so that information requirements for CHAP reporting and existing data files could be compared and missing elements determined. The results of this analysis are presented in Tables 1 and 2.

Based on the analyses, documentation for file changes and transformations was prepared, and finally a series of programs were developed which would permit facsimile CHAP Forms W-294A,

TABLE 1: Relationship of CHAP Reporting Requirements on Child Health Care Status (Form W-294A)

Form W-294A: Child Health Care Status Report. At the onset of the CHAP Program, providers are expected to fill out a Form W-294A for each eligible child in their already existing system. If the child is receiving "Appropriate Medical Supervision" this form is filled out and the child remains in the already existing system (for Roosevelt this will be the C&Y Clinic). If the form is marked showing that the child is not receiving adequate medical care, a Field worker will contact the family and encourage participation in CHAP. It appears that Roosevelt C&Y Clinic could utilize their Meditech CRT's and via Patient Registration and Patient Appointment History requests, complete the portion of the form that will change for each child. The rest of the information required for this form will be the same for each child.

Information	Other Methods	Hardcopy Roosevelt Clinical Record	Weckworth Computerized Forms	Meditech Screen Displays & Printed Output
Provider Identification	Items 1-6 are constants as R.H. is always the provider. If possible these items should be pre-printed			
Patient Identification				
(7) name		Registration form	any Contact Form	Registration Edit Routine
(8) sex		" "	" " "	" " "
(9) date of birth		" "	Registration Contact Form I	" " "
(10) identification number		" "	" " "	" " "
(11) case name		" "		" " "
(12) address		" "	" " "	" " "
(13) apartment no.		" "	" " "	" " "
(14) age	can be figured from birthdate			

Table 1 (continued)

Information	Other Methods	Hardcopy Roosevelt Clinical Record	Weckworth Computerized Forms	Meditech Screen Displays & Printed Output
(15) delayed 3rd party submission	not applicable for this form			
(16) supporting reports	" " " "			
Billing Info.				
(17) service date	date form is completed			
(18) place service	constant for Roosevelt			
(19) diagnosis code	pre-printed on form			
(20) service code	" " " "			
(21) no. of units	" " " "			
(22) amount claimed	always $5.00			
Care Status Info.				
Declaration of comprehensive med.care			available if defined	available if defined
Date of last visit		Ck.last med. exam	most recent encounter from III,IV or V from quarterly tape	patient's appointment history
Existing condition			ICDA-8 code	
Cond.being treated by reporting provider			Most recent encounter	" " "
Date of last complete physical exam		" " " "	Ck.quarterly tape for last Contact Form III with assessment-type visit	Ck.last assessment or reassessment on patient appointment history
Existing condition			ICDA-8 code	
Cond. being treated by reporting provider			Most recent encounter	Patient's appointment history

TABLE 2: Relationship of CHAP Reporting Requirement Periodic Child Health Examination Report and Claim Form (Form W-294B)

Form W-294B: Periodic Child Health Examination Report and Claim Form. Form W-294B is to be completed for each child in the CHAP Program after each periodic screening examination. The required information can be obtained from existing forms.

Information	Other Methods	Hardcopy Roosevelt Clinical Record	Weckworth Computerized Forms	Meditech Screen Displays & Printed Output
Provider Identification	Items 1-6 are constants as Roosevelt is always the provider. If possible these items should be pre-printed			
Patient Identification				
(7) name		Registration Form	any Contact Form	Registration Edit Routine
(8) sex		" "	" " "	" "
(9) date of birth		" "	Registration Contact Form I	" "
(10) identification number		" "	" "	" "
(11) case name		" "	" "	" "
(12) address		" "	" "	" "
(13) apartment no.		" "	" "	" "
(14) school			" "	
(15) borough			Can be obtained knowing school	
(16) grade	Not on any form			
(17) age	Compute from birthdate			
(18) delayed 3rd party submission		" "	Contact Form I	
(19) supporting reports				

Table 2 (continued)

Information	Other Methods	Hardcopy Roosevelt Clinical Record	Weckworth Computerized forms	Meditech Screen Displays & Printed Output
Service Performed & Billing				
(21) Place/service	Code as Roosevelt outpatient or remote team			
(22) Diagnosis code	Could be preprinted for CHAP periodic screening exam			
(23) Service code	For CHAP periodic exam, enter 9034			
(24) No. of units	For CHAP periodic exam, enter 1.0			
(25) Amount claimed	For CHAP periodic exam, set fee is $35.00			

NOTE: Items 20-25 may be repeated up to 5 times on a single form. Each line represents a separate procedure completed at the time of screening. Applicable diagnosis codes, service codes, units, and amounts are required. The CHAP provider manual is the only source of information.

(26) Total number of entry lines claimed in column 23				

FINDING FROM HISTORY AND EXAMINATION: This data is contained in Weckworth system on Contact Form III. Some information such as specific lab tests can only be found in hardcopy on Review of Systems and Physical Examination.

W-294B, and W-294C to be prepared. Copies of documentation and programs for the CHAP reporting appear as Appendix A.

At this time, early August 1975, negotiations with New York City began to obtain approval for the automated facsimilies. Despite the best efforts of the City and the Hospital, final approval was withheld until February 18, 1976. During the course of this time many changes, although limited in nature (e.g., spelling out a particular word rather than abbreviating) were instituted.

Upon approval the existing hospital data files were addressed to determine children who were Medicaid eligible at the time of their assessment during the preceding year. The file runs identified approximately 4,000 children as having been Medicaid eligible. Reports were then prepared and reimbursement forms submitted for services to these children. The same effort is carried out annually and the system continues to function with Roosevelt Hospital preparing CHAP W-294A and CHAP W-294C forms in a routine manner.

Programs have also been developed for the preparation of CHAP W-294B. However, the level of new CHAP-referred registrants has not warranted mounting the CHAP W-294B programs on a regular

basis. Consequently to facilitate the ease with which service providers prepare CHAP W-294B, a coding protocol was prepared and is presently in use at the Hospital. This protocol appears as Appendix B. (The City has requested copies of this protocol for use in modifying their own.)

Parenthetically, it is important to note that Roosevelt Hospital's history with the CHAP program has exposed particular difficulties. First, it appears that the difference between the CHAP assessment rate and the regular Medicaid rate has resulted in a number of institutional comprehensive child care providers refusing to enter the program. Therefore, although children being serviced by them are receiving comprehensive care they are not viewed by the city as obtaining care. The result is that, despite being contacted and being referred to CHAP providers many of these children do not show for scheduled visits irrespective of hospital follow-up efforts. In addition, when these children do arrive at Roosevelt Hospital and are assessed, it is frequently found that this assessment is a duplication of a similar effort recently carried out by the family's regular care provider. The situation is further complicated by the fact that the children do not return for treatment which is indicated by positive findings. To overcome this problem, Roosevelt Hospital is attempting to contact

the child's provider and alert him to any positive findings so that treatment may be provided. In almost all cases, however, the Hospital's assessment findings merely confirm what the original non-CHAP provider is already aware of. This problem must be addressed and some solution obtained.

A second automated reporting system was also developed as a consequence of this grant. Medical and Health Research Association, the New York City authority for Title V funding, in September 1976 imposed upon the Hospital new BCHS reporting requirements. After extended negotiations the City and the State, who was the ultimate recipient of the individual projects' BCHS reports, agreed to allow Roosevelt Hospital to provide a facsimile of the hardcopy reports which other Title V projects are presently providing.

As with the CHAP report, an analysis was undertaken, documentation and programs prepared. These appear in Appendix C. The final result is that the Hospital is the only institution in the State which routinely provides a data tape directly to the State in accordance with the BCHS reporting requirements. As a further note it should be pointed out that those institutions attempting to prepare hardcopy are having considerable difficulty, since the imposition of the BCHS reporting requirements has added

three additional hardcopy forms which local service providers must prepare. The errors which have obtained in hardcopy records are indicated by the letter from the New York City representative of the Title V projects, which appears in Appendix D.

At the time of this final grant report this system has not only met its monthly BCHS reporting requirements but has also produced a tape of all Title V registrants presently serviced by Roosevelt Hospital. No other institution in the State can make this claim.

EVALUATION REPORTS

In an effort to improve Roosevelt Hospital program management and patient health maintenance, a series of reports and report requirements have been developed. Some of the reports were directly available by querying existing systems, some have been developed specifically during the course of this grant, and others are contemplated for incorporation in the near future. Following are a description of the reports.

New Registrant Summary

This report provides a picture of the inflow and outflow of the basic patient data base. Quarterly new registrants by type and age are compared with program terminations by type and age. This report permits the program manager to observe changes in the basic

patient population as a function of payment category and is used for future planning purposes. It is expected that in the future this report will be augmented by a utilization summary indicating utilization of services by financial status and code. The combination of these two reports will sharpen program managers' ability to estimate future income flows.

Periodic Assessment Summary

Monthly review of the status of periodic assessment of the population is provided by this report. Included are indications of backlog (number of children who have been scheduled in the last six months and have not as yet obtained periodic assessment), those eligible this month for periodic assessment, number of periodic assessments obtained from this month's eligibles, number of periodic assessments obtained from backlog, total backlog to date. This report permits examination of the status of patient population with respect to assessments and allows for a count of the number of children who use the service on a comprehensive care basis versus the number utilizing it on an episodic basis.

Comparative Service Visits

This report is a monthly report indicating site of visit during the preceding month and comparing it to site utilization the

preceding year. It permits the program manager to examine shifts in utilization of specialty as well as shifts in utilization of pediatric teams. It serves as an early indicator of changes in utilization and problems of provider capability.

Visit Type Analysis

Monthly, this report provides a display of type of patient visit behavior. It allows comparison of scheduled, walk-ins, and no-show appointments. It is expected that in the future this report will be available by age and time of day so that it may be used to determine reasons for no-shows.

Contagious Diseases Summary

This report is presently required by New York City. It indicates children by contagious diseases. In the future, it is expected that this analysis will be carried out by geographical location and school attended, so that early indications of contagion may be transmitted to local groups.

CHAP Equivalent Assessment Summary

This report results from periodic review of the files to determine children who are Medicaid eligible although not CHAP referred, who have received an assessment during the preceding 12 months.

Comparisons with the preceding year provide the program manager with an added income estimation tool.

Equivalence Assessment Summary

This report, planned for development in the future, will summarize health status of the patient population on a 6-month basis. It will be used to determine children who have received all tests, immunizations, and exams required by an assessment during the course of their episodic utilization of the service. It will provide a more accurate picture of the patient population under comprehensive care.

Immunization Status Summary

This report will provide an indication of children whose immunization status is not up to date. In addition to summary counts, individual listing will also be prepared and used to schedule patients for required prevention visits.

Productivity Analysis

This report, planned for the future, would assess general pediatric services and specialty services on the basis of diagnosis and procedures. It will be used as a rapid indicator of provider under- and overloads and serve as an aid to planning further patient input.

Drug Profile

This report, in the developmental stages at present, will provide an analysis of drug prescription by provider and patient utilization. It is expected that it will permit better control of drug utilization as well as more appropriate use of generic drugs.

INFORMATION REQUIREMENTS FOR USE IN PEDIATRIC AMBULATORY SERVICES

During the course of this grant, attention was focused on the development of reporting, planning, and evaluation systems. While the present data systems at Roosevelt Hospital were sufficient with minor modifications to demonstrate the intent of the grant, namely to use existing data systems to meet new reporting requirements, much attention focused on the improvement of local planning and evaluation. While devising reports necessary to improve the planning and evaluation of the pediatric ambulatory service it became clear that additional information would be required. As a consequence, time and effort were put into development of an all-inclusive list of information requirements for registration, initial health history, and medical encounters. These information requirements appear as Appendix E.

At present the Hospital is continuing its efforts which were initiated under the grant and it is presently comparing information collected

from various sources within the service to determine critical data points which may be missing. Subsequently changes in data collection procedures will be recommended to ensure that the data will meet utilizer needs.

APPENDIX A

CHAP REPORTING SYSTEM DOCUMENTATION

1. Letters approving use of computer printed facsimiles
2. Procedures for operations
3. Programs for producing facsimiles

W-1

The City of New York

HUMAN RESOURCES ADMINISTRATION
250 CHURCH STREET, NEW YORK, N. Y. 10013

JAMES R. DUMPSON, *Administrator/Commissioner*

Department of Social Services
Child Health Assurance Program
305 Broadway, (Room 309)
New York, New York 10007
October 17, 1975

Louis F. Cooper, M.D.
Director of Pediatrics
The Roosevelt Hospital
428 West 59th Street
New York, New York 10019

Dear Dr. Cooper:

We are pleased to approve your latest facsimiles of:

1) the Child Health Care Status Report, 2) the Summary Claim Sheet, and 3) Affidavit, copies of which are included with this letter.

As for invoice number, you will be requested to use the invoice numbers in consecutive order from Z100001 through Z200000 for the Child Health Care Status Report and from Z100001 through Z110000 for the Summary Claim Form.

Sincerely,

Seymour Klass
Director

cc: Ilene Bussman
Betsey Hall
Encl: Facsimiles of:
1) Child Health Care Report
2) Summary Claim Sheet
3) Affidavit

THE CITY OF NEW YORK
CHILD HEALTH ASSURANCE PROGRAM
DEPARTMENT OF SOCIAL SERVICES
305 BROADWAY (2ND FLOOR)
NEW YORK, N.Y. 10007

SUMMARY CLAIM SHEET

INVOICE NO
R000001

CLAIM CONTROL NO

PROVIDER ID NO	NAME	ADDRESS
440156160	ROOSEVELT HOSP	428 W 59 ST NYC, NY

PERIOD COVERED
MO DA YR TO MO DA YR

PAGE 1 OF 1 PAGES

INVOICE NOS FOR SUMMARY CLAIM SHEETS

TOTAL NO OF CLAIMS

LN NO	INVOICE NO	SERV DATE	CASE NAME	PATIENT ID NO	S E X	BIRTH DATE	FIRST NAME	TOTAL DOLLAR CLAIM	CHAP USE ONLY
1									
2									
3									
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REVIEWED BY

AUTHORIZED BY

CONSTRED TOTAL CLAIMED

NO VALID CLAIMS

ADJUSTMENTS

CHECK FOR

AFFIDAVIT: I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ITEMIZED HAVE BEEN FURNISHED; THE AMOUNTS LISTED ARE DUE AND, EXCEPT AS NOTED, NO PART THEREOF HAS BEEN PAID. PAYMENT OF FEES AND RATES IN ACCORDANCE WITH PAID. PAYMENT OF FEES AND RATES MADE IN ACCORDANCE WITH ESTABLISHED SCHEDULES IS ACCEPTED AS PAYMENT IN FULL, AND THERE HAS BEEN COMPLIANCE WITH TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT OF 1964 WITHOUT DISCRIMINATION ON THE BASIS OF RACE, COLOR OR NATIONAL ORIGIN. I AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY OF SUCH ITEMIZED CARE, SERVICES AND SUPPLIES WHICH I HAVE PROVIDED AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED THEREFOR AS THE LOCAL SOCIAL SERVICES AGENCY OR THE STATE DEPARTMENT OF SOCIAL SERVICES MAY REQUEST. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT.

PROVIDERS SIGNATURE DATE

THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
CHILD HEALTH ASSURANCE PROGRAM
305 BROADWAY (3RD FLOOR)
NEW YORK, N.Y. 10007

PERIODIC CHILD HEALTH EXAMINATION
REPORT AND CLAIM FORM

INVOICE NO
9100004

CLAIM CONTROL NO

PROVIDER ID

PROVIDER ID NO 440195160 NAME ROOSEVELT HOSP

ADDRESS
428 W59 ST MAN NYC NY

GROUP PHONE 5547475 SPECIALTY PEDIATRICS

PATIENT ID

NAME (LAST FIRST) JONES JOHN SEX M BIRTH 12/65

ID NO 12345670 CASE NAME JONES

ADDRESS 450 W59 ST NYC APT 11A

SCHOOL PS 32 BOR MAN GRADE 4 AGE 10

DELAYED 3RD PARTY NO SUPPORT REPORTS NO

LN	SERVICE DATE	PLACE SERVICE	DIAGNOSIS CODE	SERVICE CODE	NO UNITS	AMT CLAIM	DIM USE ONLY
	DDAYR	CD ZIP					
101	120175	410019	Y00.0	9034	1.0	35.00	

CHILD IS OR WILL BE IN MY CONTINUING CARE YES
IS THIS THE FIRST PERIODIC HEALTH EXAM FOR THIS CHILD DURING THIS YEAR? YES

INVOICE NO
P100004

FINDINGS FROM HISTORY AND EXAMINATION

CONDITIONS	NORMAL	FURTHER MEDICAL ATTENTION SHOULD BEGIN WITHIN 1 WK	1 MO	2-6 MOS	REFERRALS NAME OF CLINIC AND DATE OF APPT
1 HISTORY, GROWTH AND DEVELOPMENT	X				
2 SPEECH	X				
3A VISION	X				
B HEARING	X				
4 LAB TESTS PERFORMED					
A ANEMIA (HB OR HR)	X				
B URINALYSIS	X				
C SICKLE CELL (AS IND)	X				
D LEAD POISONING (AS IND)	X				
E TUBERCULIN	X				
F VDRL/GC (AS IND)	X				
6 PHYSICAL EXAMINATION					
A EYE	X				
B EAR	X				
C NOSE	X				
D MOUTH AND THROAT	X				
E DENTAL SEEN IN LAST YEAR	N				12/15/75 ROOSEVELT
F HEAD AND NECK	X				
G CHEST (CARDIOPULMONARY (CXR IF OVER 3 YEARS)	X				
H ABDOMEN	X				
I GENITO-URINARY	X				
J MUSCULO-SKELETAL (INCLUDE POSTURE)	X				
K NEUROLOGICAL	X				
L CONDITION OF SKIN	X				
M BEHAVIOR	X				
N OTHER (SPECIFY)	X				

IMMUNIZATIONS	GIVEN	ADDITIONAL DOSES (REQUIRED)
DPT	12/01/75	
POLIO	COMPLETE	
MEASLES	HAD DISEASE	
RUBELLA	NA	
MUMPS	12/01/75	2

ADDITIONAL INFORMATION REMARKS:

INVOICE NO
0160004

AFFIDAVIT: I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ITEMIZED HAVE BEEN FURNISHED; THE AMOUNTS LISTED ARE DUE AND, EXCEPT AS NOTED, NO PART THEREOF HAS BEEN PAID. PAYMENT OF FEES AND RATES MADE IN ACCORDANCE WITH ESTABLISHED SCHEDULES IS ACCEPTED AS PAYMENT IN FULL; AND THERE HAS BEEN COMPLIANCE WITH TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT OF 1964 WITHOUT DISCRIMINATION ON THE BASIS OF RACE, COLOR OR NATIONAL ORIGIN. I AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY OF SUCH ITEMIZED CARE, SERVICES AND SUPPLIES WHICH I HAVE PROVIDED AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED THEREFOR AS THE LOCAL SOCIAL SERVICES AGENCY OR THE STATE DEPARTMENT OF SOCIAL SERVICES MAY REQUEST. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT.

EXAM COMPLETED DATE(MO DA YR)

PROVIDERS SIGNATURE DATE(MO DA YR)

THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
CHILD HEALTH ASSURANCE PROGRAM
305 BROADWAY (3RD FLOOR)
NEW YORK, N.Y. 10007

CHILD HEALTH CARE STATUS REPORT

INVOICE NO
8000001

CLAIM CONTROL NO

PROVIDER ID

PROVIDER ID NO	NAME
440196160	ROOSEVELT HOSP

ADDRESS	
428 W59 ST MAN NYC NY	

GROUP PHONE	SPECIALTY
5547479	PEDIATRICS

PATIENT ID

NAME (LAST FIRST)	SEX	BIRTH
JONES JOHN .	M	1/75

ID NO	CASE NAME
55555550	JONES

ADDRESS	APT
428 W 58 ST NYC	A11

AGE	DELAYED 3RD PARTY	SUPPORT REPORTS
10	NO	NO

SERVICE DATE	PLACE SERVICE	DIAGNOSIS CODE	SERVICE CODE	NO UNITS	AMT CLAIM	DIM USE ONLY
MOLAYR	CD ZIP					
1 1/5	4 10019	Y00.0	9000R	1.0	5.00	

TOTAL ENTRY LINES 1 5.00 TOTAL AMOUNT

MEDICAL CARE STATUS

YES
CHILD IS IN BY CONTINUING CARE, AND HAS HAD OR IS RECEIVING THE NECESSARY PHYSICAL EXAMINATION, IMMUNIZATIONS, GROWTH AND DEVELOPMENTAL EVALUATIONS AND LABORATORY TESTS FOR HIS AGE AND SEX. WHERE APPROPRIATE, SICKLE CELL, ANEMIA, LEAD POISONING TESTS AND RELATED LABORATORY WORK HAVE BEEN PERFORMED.

LAST VISIT MO DA YR
1/ 1/75

LAST EXAM MO DA YR
1/ 2/75

DIAGNOSIS ICDA
XXXX

DIAGNOSIS ICDA
XXXX

CONDITION TREATED BY
REPORTING PROVIDER

CONDITION TREATED BY
REPORTING PROVIDER

PROCEDURE USED TO PRODUCE CHAP FORMS A & C

1. Information obtained from Meditech:

   - RH data files do not contain case names for Medicaid numbers

   - Developed file EMS.MEDV containing unit code (Y for Project Children), unit number, medicaid number, case name.

2. Use RH data file "C & YMaster" to match with EMS.MEDV and create EMS.YM which contains registration information on patients contained in both files

   - Only those with Medicaid numbers in both files

   - Check for 7 digit Medicaid number and non-blank case name

3. Read total transaction file and create EMS.TRAN containing encounters within acceptable backdating range (18 months).

   - Appropriate time is immediately after quarterly runs

4. Scan EMS.TRAN and find patients with assessments (or reassessments) and visits within time range

   - Create file.VA by matching registration information on Master file with visits

   - .VA will contain visit and assessment information which matches an entry in EMS.YM only (there are assessments which will not match .YM - these will be considered separately)

5. Create .YM1 from .YM by matching with .VA; thus .YM1 will contain registration data only on children in .VA (a one to one relation of these files)

6. .YM1 and .VA are used as input to the program which produces facsimilies of CHAP W294A.

7. The CHAPA program creates 2 files:

   - .CHAPA which contains pertinent information on children who have been filed with city DSS. This file would be searched to be sure chidlren are not reported twice.

- .CHAP C which contains information needed to produce CHAP C

8. .CHAPC is input to the program which produces facsimilies of CHAP W294C.

The preceding example is the simplest case and would be done immediately after the quarterly runs. The steps are slightly different as a new file .YM would be matched with .CHAPA and any children who have been previously reported would be deleted from .YM before a search of assessments.

The first 6 steps were followed a second time using files on children with non-matching Medicaid numbers from MEDV & Master file (the Medicaid number on MEDV was used. Steps 7 & 8 were repeated and .CHAPA & .CHAPC were modified to contain these newly reported children.

This procedure will be followed in reporting non-project children on whom data is now to be keypunched and compiled.

Children who have been reported to DSS manually will be added to files .CHAPA and .CHAPC.

FILES NORMALLY MAINTAINED BY C&Y PROJECT - ALL ON TAPE

1. C&Y MASTER - format FB
   Record Length - 463
   Block Size 2315
   Blocked - 5

   Contains registration information on C&Y project children only.

   All information on registration contact form keypunched & updated weekly as normal procedure.

   Used quarterly to produce reports for Maternal & Child Health

2. 'PMI QTLY TRANS' - format FB
   Record Length - 80
   Blocksize - 80
   Blocked - 1

   contains encounter data on CTY project children only:

   contact forms III, IV & V, containing medical, dental & nursing data are keypunched & updated weekly as normal procedure

   Used quarterly to produce reports for Maternal and Child Health -

   At quarterly report runs - data is merged into Total Transaction File

3. TOTAL TRANS CUM270' Format FB
   Record Length 80
   Block Size 1600
   Blocked 20

   Contains entire history file of transactions on all project children - begun 1968

   Sorted by unit number, then date of encounter

   Updated quarterly by 'PMI QTLY TRANS'

Weekly Procedure to Maintain

C&Y Data Files

Revised 6/10/76

I. EDIT - The first job contains 3 steps

1. Step 1 - Scratch 5 disk data sets used for output

   A.CYT.YTRANS - to contain Y transactions

   B.CYT.NTRANS - to contain N transactions

   C.CYT.ITRANS - to contain I transactions

   D.CYT.OTRANS - to contain O transactions

   E.CYT.REGS - to contain all registration cards

2. Step 2 - Sort all input by unit number and card type and write to a disk data set. The input data cards follow the //SORTIN Ø DD Ø* JCL card

3. Step 3 - Major edit routine which reallocates the above five files and edits all data cards on unit number. Input with illegal unit numbers is printed on an error list. All data on transaction cards (Type III, IV and V cards) is edited, an error list is produced and acceptable data is written to the appropriate file based on unit type code (Y,N,I,O). In addition registration cards (Type I, II and VII) with acceptable unit numbers are written to the fifth file, CYT.REGS, to further processing, EDIT requires a date card before the final /* card at the end of the

deck. The date should be punched MODAYR (eg: 030176 in card columns 1 to 6).

II. MERGE - The second job deck contains four steps each of which merges the transactions written by EDIT to the matching cummulative tape file. In each step, the two JCL cards which contain the volume serial number of the tapes to be used that week must be latered prior to processing. This is explained in the section describing the tapes to be maintained and the updating procedure.

III. REDIT - The first step of REDIT scratches data set CYR.REGS to be used for output. Also, the four output data sets of job UPDATE (CY.YR, CY.NR, CY.IR, CY.OR) are scratched. The second step edits all registration information (name, dates, Medicaid numbers, etc.), and decides if input cards are complete (new) registrations or update (correction) information. An error list is produced containing both data errors and incomplete new registration. Acceptable data is written to file CYR.REGS, which is reallocated.

IV. UPDATE - This routine uses the output of REDIT and expands the data into 463 character records to meet the specifications of the master files. These expanded records are written to the appropriate update file based

on unit type codes (Y, N. I, O). The four disk data sets which are reallocated are:

A.CY.YR - Y registrations

B.CY.NR - N registrations

C CT,UR - U registrations

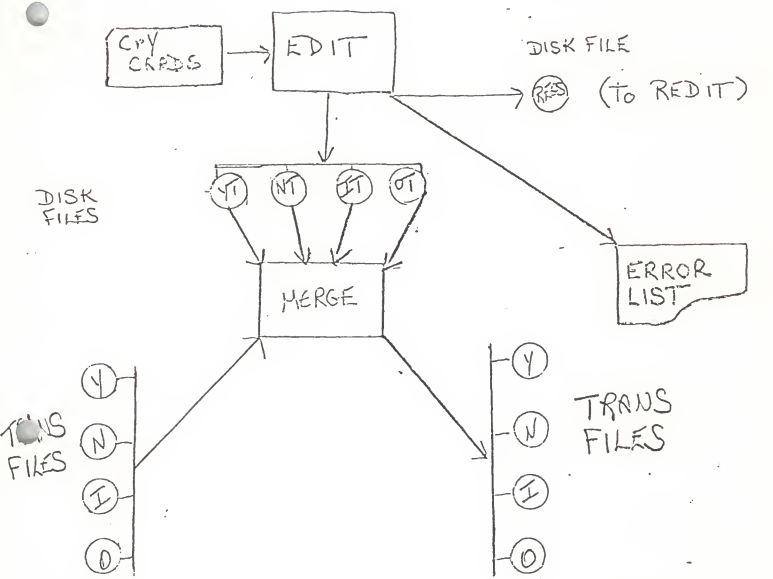
D CY.OR - O registrations

V. COPY - This routine copies the 4 update data sets produced by job UPDATE to 4 DOS tapes for input to UPMERGE. Each tape is labelled with the data set name and the step number (YR-STEP 1, NR-STEP 2, IR-STEP 3, OR-STEP 4). Series tapes are not necessary as the same tapes are used over again each week.

VI. UPMERGE - UPMERGE runs under the DOS system. The final job in weekly processing is run four times, once for each of the master files. Input is an update file produced by the last job, UPDATE, and copied to tape by job copy (on 282) and the previous week's master file (on 283) and output is a new master file (on 284). In addition, a B1 report is produced. This listing contains formatted data of new registrations and corrections produced by the week's runs.

VII. Y1 - This job will be urn on request only. Master file information will be sorted on patient name and a Y1 report will be produced in a format similar to the B1 report in UPMERGE. Due to the print time required for this listing, job Y1 will not be part of the normal weekly processing.

CPY WEEKLY PROCESSING
REVISED 6/10/76



TAPES-
OUTPUT
of MERGE
(LAST WEEK)

Y, I - ONE TAPE

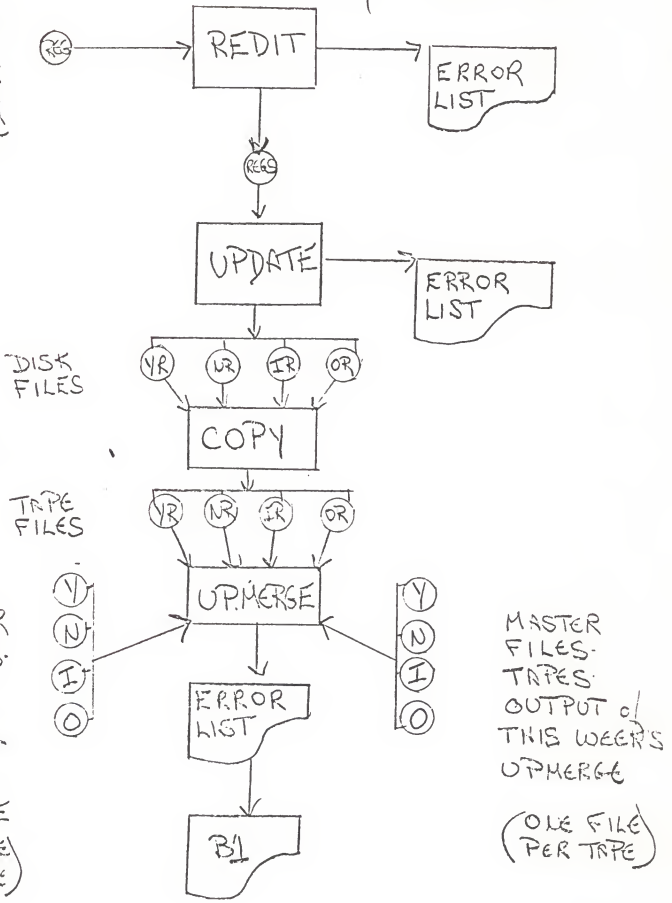
N, O - ONE TAPE

TAPES -
OUTPUT
OF MERGE
(THIS WEEK)

Y, I - ONE TAPE

N, O - ONE TAPE

CPY Weekly PROCESSING REVISED 6/10/76



```
//EMSCHAP JOB CLASSEF,TIME=1440
//EMSCHAP EXEC PGM=IEYFORT,REGION=100K
//SYSPRINT DD SYSOUT=A
//SYSPUNCH DD SYSOUT=B
//SYSLIB DD DSNAME=LOADSET,DISP=(OLD,PASS),UNIT=SYSSD,
//  SPACE=(80,(200,100),RLSE),DCB=BLKSIZE=80
//FORT.SYSIN DD *
FORTRAN STMT. FOR EMSCHAP  FORT
IEW2961 103   ALLOCATED TO SYSLIN
IEW2978 - STEP WAS EXECUTED - COND CODE 0000
IEW2957 SYS25319.T103410.RF103.EMSCHAP.LOADSET        PASSED
IEW2957 WTL SCR NOS= 00002.
//XXXXXXXX DD DSNAME=SYS1.FORTLIB,DISP=SHR
//XXXXXXXX DD DSNAME=LOADSET(MAIN),DISP=(NEW,PASS),UNIT=SYSSD,
//  SPACE=(80,(20,10,11),RLSE),DCB=BLKSIZE=1024
//XXXXXXXX DD SYSOUT=A
//SYSUTL DD UNIT=SYSSD,SPACE=(1024,(100,10),RLSE),DCB=BLKSIZE=1024.
//  DSNAME=SYSUT1
//SYSLIN DD DSNAME=LOADSET,DISP=(OLD,DELETE)
//  DD  DDNAME=SYSIN
IEW2961 101   ALLOCATED TO SYSLIN
IEW2961 102   ALLOCATED TO SYSLIB
IEW2961 103   ALLOCATED TO SYSUT1
IEW2961 103   ALLOCATED TO SYSLIN
IEW2978 - STEP WAS EXECUTED - COND CODE 0000
IEW2957   SYS1.FORTLIB                                KEPT
IEW2957   WTL SCR NOS= SYS3FS.
IEW2957   SYS25319.T103410.RF103.EMSCHAP.GOSET        PASSED.
IEW2957   WTL SCR NOS= 00002.
IEW2957   SYS25319.T103410.RF103.EMSCHAP.SYSUT1       DELETED
IEW2957   WTL SCR NOS= 00001.
IEW2957   SYS25319.T103410.RF103.EMSCHAP.LOADSET      DELETED
IEW2957   WTL SCR NOS= 00002.
//XXXXXXXX EXEC PGM=IEWL,PARM=(MAP,LET,LIST),COND=((4,LT,FORTL),(4,LT,LKED))
//XXXXXXXX DD DSNAME=LOADSET,DISP=(OLD,DELETE)
//XXXXXXXX DD DSNAME=SYS1.FORTLIB,UNIT=SYSSD,DISP=SHR
//XXXXXXXX DD DSNAME=SYS1.VFM,UNIT=SYSSD,DISP=SHR
//XXXXXXXX DD DSNAME=EMS.GHARD,UNIT=SYSSD,VOL=SER=RESLIB,
//  DSNAME=EMSVFM,DCB=(RECFM=U,BLKSIZE=14254,SPACE=(CYL,(1,1)),
//  DSNAME=EMSGHARD,DCB=(RECFM=U,BLKSIZE=32001,SPACE=(CYL,(5,1)),
//  DSNAME=SYSLIN
//XXXXXXXX DD SYSOUT=A
//SYSPRINT DD SYSOUT=C,DCB=(
//XXXXXXXX EXEC PGM=EMSCHAP  SD
IEW2961 101   ALLOCATED TO DS=*.DD
IEW2961 101   ALLOCATED TO RT33F001
IEW2961 101   ALLOCATED TO RT33F001
IEW2961 101   ALLOCATED TO RT33F001
IEW2961 101   ALLOCATED TO RT33F001
IEW2978 - STEP WAS EXECUTED - COND CODE 0000
IEW2957   SYS25319.T103410.RF103.EMSCHAP.GOSET        PASSED
IEW2957   WTL SCR NOS= 00002.
IEW2957   EMS.VS                                      KEPT
IEW2957   WTL SCR NOS= MSSLIB.
IEW2957   EMS.VFM                                     KEPT
IEW2957   WTL SCR NOS= MSSLIB.
IEW2957   EMS.GHARD                                   NOT CATLGD  2
```

```
IEF287I   VOL SER NOS= RESLIB.                                  NOT CATLGD  2
IEF287I   FMS.CHAPA
IEF287I   VOL SER NOS= RESLIB.
IEF285I   SYS75313.T193419.RF103.FMSCHAP.GOSET                  DELETED
IEF285I   VOL SER NOS= PRO002.
IEF285I   FMSCHAP  SYSOUT=A,C.
```

```
      LOGICAL*1 MCASE(20),ADD(26)
      INTEGER NAME(22),BLK/' '/,COM/','/
      INTEGER FNAME(22)
      LOGICAL*1 Z/'Z'/
      INTEGER Y/'Y'/
      INTEGER STATUS
      INTEGER BLANK/'    '/
      INTEGER MM,YY,AGE,MO,DA,YR,VMO,VDA,VYR
      INTEGER AMO,ADA,AYR
      REAL*8 MEDI
      INTEGER (CD1(3),ICD2(3)
      LOGICAL*1 ICDA(109,30)
      INTEGER SEX,ONE/'1'/,TWO/'2'/,MALE/'M'/,FEM/'F'/
      READ(5,31) INV
   31 FORMAT(I6)
      DO 90 K=1,109
      READ(5,30) (ICDA(K,I),I=1,30)
   30 FORMAT(4X,30A1)
   90 CONTINUE
      READ(5,22) MO,DA,YR
   22 FORMAT(3I2)
      DO 100 K=1,919
      READ(1,40) MID,MEDI,(MCASE(I),I=1,20),(NAME(I),I=1,22),
     AIADD(I),I=1,20),SEX,MM,YY,APT
   40 FORMAT(I6,A7,20A1,5X,22A1,9X,20A1,26X,A1,2X,I2,2X,I2,117X,A3)
      IF(SEX.EQ.ONE) SEX=MALE
      IF(SEX.EQ.TWO) SEX=FEM
      IF(MM.GT.MO) YY=YY+1
      AGE=YR-YY
      READ(2,41) VMO,VDA,VYR,(ICD1(I),I=1,3)
      READ(2,41) AMO,ADA,AYR,(ICD2(I),I=1,3)
   41 FORMAT(7X,3I2,5X,3I3)
      WRITE(6,51)
   51 FORMAT(20X,'THE CITY OF NEW YORK'/20X,'DEPARTMENT OF SOCIAL SERVIC
     1ES'/20X,'CHILD HEALTH ASSURANCE PROGRAM'/
     A20X,'305 BROADWAY (3RD FLOOR)'/
     220X,'NEW YORK, N.Y. 10007')
      WRITE(6,1) INV,(NAME(I),I=1,20),SEX,MM,YY
      WRITE(6,2) MEDI,(MCASE(I),I=1,19),(ADD(I),I=1,26),APT
      WRITE(6,3) AGE,MO,DA,YR
      WRITE(6,4) VMO,VDA,VYR,AMO,ADA,AYR
      WRITE(6,7)
    7 FORMAT(//5X,'DIAGNOSIS    ICDA',20X,'DIAGNOSIS    ICDA')
      IF(ICD1(1).LT.1.OR.ICD1(1).GT.108.AND.(VMO.EQ.AMO.AND.VYR.EQ.AYR))
     AICD1(1)=ICD2(1)
      IF(ICD2(1).LT.1.OR.ICD2(1).GT.108.AND.(VMO.EQ.AMO.AND.VYR.EQ.AYR))
     AICD2(1)=ICD1(1)
      IF(ICD1(1).LT.1.OR.ICD1(1).GT.108) ICD1(1)=103
      IF(ICD2(1).LT.1.OR.ICD2(1).GT.108) ICD2(1)=103
      DO 90 L=1,3
      IF(ICD1(L).LT.1.OR.ICD1(L).GT.108) ICD1(L)=109
      IF(ICD2(L).LT.1.OR.ICD2(L).GT.108) ICD2(L)=109
      I1=ICD1(L)
      I2=ICD2(L)
```

```
0049          WRITE(6,51 (ICDA(I1,I),I=1,30),(ICDA(I2,I),I=1,30)
0050        5 FORMAT(1X,30A1,10X,30A1)
0051          IF(ICD(1).EQ.1091 ICD(1)=0
0052          IF(ICD(1).EQ.1091 ICD(1)=0
0053       22 CONTINUE
0054          WRITE(4,3)
0055        4 FORMAT(/5X,'CONDITION TREATED BY',16X,'CONDITION TREATED BY'/
             15X,'REPORTING PROVIDER',18X,'REPORTING PROVIDER'1
0056        1 FORMAT(//15X,'CHILD HEALTH CARE STATUS REPORT'///
             15X,'INSURANCE NO',25X,'CLAIM CONTROL NO',5X,'Z',I5//
             410X,'PROVIDER ID',13X,'PATIENT ID'//
             71X,'PROVIDER ID NO',4X,'NAME',
             76X,'NAME (LAST FIRST)',5X,'SEX',1X,'BIRTH'/
             41X,'9431061160',4X,'DOUGHELL HOSP',3X,2A1,3X,A1,2X,I2,'/',I2)
0057        2 FORMAT(/3X,'ADDRESS',22X,'ID NO',6X,'CASE NAME'/
             11X,'423 453 ST MAN XYZ NY',9X,A8,4X,I9/1//
             21X,'BROOD',1X,'BRONX',7X,'SPECIALTY',3X,'ADDRESS',20X,'ART'/
             16X,'5367475',1X,'PEDIATRICS',7X,2A1,1X,A3)
0058        3 FORMAT(/11X,'AGE',3X,'DELAYED  NO',3X,'SUPPORT  NO'/
             131X,I2,4X,'3RD PARTY ',4X,'REPORTS'///
             23X,'SERVICE',2X,'PLACE',2X,'DIAGNOSIS',2X,'SERVICE',3X,'NO',4X,
             3'RATE',5X,'DIM USE'/3X,'DATE',3X,'SERVICE',4X,'CODE',5X,'CODE',3X,
             4'UNITS',2X,'CLAIM',4X,'PAID'//2X,'MONTH',2X,'CD ZIP'/
             52X,I2,2X,'6 1001P',4X,'YY',3X,'5238',4X,'1.0',4X,'5.00'//
             61X,'TOTAL ENTRY LINES 1',5X,' 5.00  TOTAL AMOUNT'//)
0059        4 FORMAT(20X,'MEDICAL CARE STATUS'//10X,'YES'/2X,
             2'CHILD IS IN MY CONTINUING CARE, AND HAS HAD OR IS RECEIVING'/
             3X,'THE NECESSARY PHYSICAL EXAMINATION, IMMUNIZATIONS, GROWTH AND'
             5/2X,'DEVELOPMENTAL EVALUATIONS AND LABORATORY TESTS FOR HIS AGE ',
             2'AND'//2X,'SEX.  WHERE APPROPRIATE, SICKLE CELL, ANEMIA, LEAD',
             8'POISONING'/2X,'TESTS AND RELATED LABORATORY WORK HAVE BEEN ',
             5'PERFORMED.'//
             3/5X,'LAST VISIT  MO DA YR',16X,'LAST EXAM  MO DA YR'/
             517X,I2,'/',I2,'/',I2,27X,I2,'/',I2,'/',I2)
0060          WRITE(4,5)
0061        6 FORMAT(////1X)
0062          I1=0
0063          DO 79 J=1,22
0064          NAME(J)=BLK
0065       79 CONTINUE
0066          DO 70 J=3,21
0067          IF(I1.NE.0) GO TO 71
0068          IF(NAME(J1.EQ.BLK.OR.NAME(J1.EQ.COM) I1=J
0069          GO TO 70
0070       71 IF(NAME(J1.NE.BLK.AND.NAME(J1.NE.COM) GO TO 70
0071          I2=J
0072          LEN=I2-I1
0073          IF(LEN.LT.3) GO TO 70
0074          IF(NAME(J+1).EQ.BLK.OR.NAME(J+2).EQ.BLK) GO TO 75
0075          I1=I2
0076       70 CONTINUE
0077       75 J1=I1+1
0078          DO 76 J=J1,22
0079
```

```
      JJ=JJ+1
      ENAME(JJ)=NAME(J)
   74 CONTINUE
      WRITE(3,300) Z,INV,MD,MP,(MCASE(I),I=1,20),SEDI,SEX,XY,YY,
     *(ENAME(I),I=1,10)
  300 FORMAT(A1,I6,2I2,20A1,A8,3X,A1,2I2,10A1)
      STATUS=Y
      WRITE(4,301) Y,MID,(NAME(I),I=1,20),SEX,XY,YY,SEDI,
     *(MCASE(I),I=1,20),ENF,Y,MID,(ADD(I),I=1,20),ART,MD,DA,YR,STATUS,
     *BVMD,VDA,VYR,(ICOL(I),I=1,3),AMP,ADA,AYR,(ICOD(I),I=1,3),TWO
  301 FORMAT(A1,I6,22A1,3X,A1,2I2,A8,3X,20A1,11X,A1/
     *A1,I6,20A1,10X,A3,3I2,A1,3I2,3I2,3I2,3I2,2X,A1)
      INV=INV+1
  100 CONTINUE
      STOP
      END
```

SUBPROGRAMS CALLED

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
IBCOM#	140								

SCALAR MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MEDI	150	BLK	158	COM.	15C	Y	160	BLANK	164
ONE	168	TWO	16C	MALE	170	FEM	174	INV	178
K	17C	I	18D	MO	184	DA	188	YR	18C
MID	190	SEX	194	MM	198	YY	19C	ART	[illegible]
[illegible]	1A4	VMO	1A8	VDA	1AC	VYR	1B0	ABO	[illegible]
[illegible]	1B8	AYR	1BC	L	1C0	I1	1C4	I2	[illegible]
J	1CC	LEN	1D0	JJ	1D4	J1	1D8	STATUS	[illegible]
Z	1E0								

ARRAY MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MCASE	1E1	ADD	1E5	NAME	210	FNAME	268	ICD1	[illegible]
ICD2	2CC	ICDA	2D8						

FORMAT STATEMENT MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
31	50F	30	FA2	22	FAA	40	FED	41	F[illegible]6
51	FE4	7	1079	5	1045	8	1083	1	1113
2	1159	3	129A	4	13E1	6	1599	800	15A2
801	15BE								

OPTIONS IN EFFECT NOID,EBCDIC,SOURCE,NOLIST,NODECK,LOAD,MAP
OPTIONS IN EFFECT NAME = MAIN , LINECNT = 56
STATISTICS SOURCE STATEMENTS = 91,PROGRAM SIZE = 8678
STATISTICS NO DIAGNOSTICS GENERATED

```
E66-LEVEL LINKAGE EDITOR OPTIONS SPECIFIED XREF,LIST,LET
      DEFAULT OPTION(S) USED -  SIZE=(123032,24376)


                                  CROSS REFERENCE TABLE

CONTROL SECTION                                ENTRY
  NAME    ORIGIN  LENGTH                         NAME   LOCATION    NAME   LOCATION    NAME   LOCATION    NAME   LOCATION
PATM        00     2F6
INCRCOMM  2F08     C00                          INCOM#    2F08     FRIOCS#   2F0A     INTERTCH   2F46
                                                AIBIA#    3F02
INCRCVTH  3200    1100                          INCRCVTH  3200     RCVCOMTP  3202     RCVCOMT2   3204     RCVCOMT3   3206
                                                RCVTIOTP  3208     RCVCOOTP  320A     RCVCOOT2   320C     INTASWCH   320E
INCRITCH  4400     3F0                          AB1TH#    4400     ADJSWTCH  4F00
INCRIOSM  4800    1D06                          FIOCS#    4800
INCRIOOT  5A00       0
INCRTCH   5A00     3F4                          INCERRM   5A08
INCHATBL  5E00     38
```

```
LOCATION  REFERS TO SYMBOL  IN CONTROL SECTION   LOCATION  REFERS TO SYMBOL  IN CONTROL SECTION
   1A0        INCOM#        INCRCOMM              2F44       SEJJA#          INCOM#
   2000       ACCOM#        INCRCVTH              2F48       FIOCS#          INCRIOSM
   2004       AB1TH#        INCRITCH              2F4A       ADJSWTCH        INCRITCH
   2008       INCIOOT       INCIOOT               2F4C       RCVCOMTP        INCRCVTH
   200C       RCVCOMTP      INCRCVTH              2F50       RCVTIOTP        INCRCVTH
   2010       RCVCOOTP      INCRCVTH              2F54       RCVCOOTP        INCRCVTH
   2014       RCVTIOTP      INCRCVTH              2F58       INCCOMM2        INCRCOMM
   2018       INCRCOMM      INCRCOMM              2F5A       INCRCOMM        INCRCOMM
   2F00       INCRTCH       INCRTCH               2F10       INCERRM         INCRTCH
   2154       INCRCOMM      INCRCOMM              4200       INCOM#          INCOM#
   2F0C       INCOM#        INCRCOMM              4204       ACCOM#          INCRCOMM
   4218       INCERRM       INCRTCH               4208       INTASWCH        INCRCVTH
   4210       INTERTCH      INCRCVTH              4F94       ADCOM#          INCRCVTH
   4210       INCIOOT       INCIOOT               4F98       INCERRM         INCRTCH
   4F34       FIOCS#        INCRIOSM              4F9A       INCOM#          INCRCOMM
   5A7B       INCHATBL      INCHATBL              5A34       ADCOM#          INCRCVTH
   5A80       INCOM#        INCRCOMM              5A34       ADCOM#          INCRCVTH
   5A92       FIOCS#        INCRIOSM
ENTRY ADDRESS      00

TOTAL LENGTH      5B28
***WARNING  DOES NOT EXIST BUT HAS BEEN ADDED TO DATA SET
TERMINATION CODE IS        0.
```

```
FFFFFFFFFFFF  MM        MM   SSSSSSSSSS   CCCCCCCCCC   HH        HH   AAAAAAAAAA   PPPPPPPPPP
FFFFFFFFFFFF  MMM      MMM  SSSSSSSSSSS  CCCCCCCCCCC  HH        HH  AAAAAAAAAAAA  PPPPPPPPPPP
FF            MMMM    MMMM  SS        SS  CC        CC  HH        HH  AA        AA  PP        PP
FF            MM MM  MM MM  SS            CC            HH        HH  AA        AA  PP        PP
FF            MM  MMMM  MM  SSS           CC            HH        HH  AA        AA  PP        PP
FFFFFFFF      MM   MM   MM   SSSSSSSSS    CC            HHHHHHHHHHHH  AAAAAAAAAAAA  PPPPPPPPPPP
FFFFFFFF      MM        MM    SSSSSSSSS   CC            HHHHHHHHHHHH  AAAAAAAAAAAA  PPPPPPPPPP
FF            MM        MM            SSS CC            HH        HH  AA        AA  PP
FF            MM        MM             SS CC            HH        HH  AA        AA  PP
FF            MM        MM  SS         SS  CC        CC  HH        HH  AA        AA  PP
FFFFFFFFFFFF  MM        MM  SSSSSSSSSSS   CCCCCCCCCCC   HH        HH  AA        AA  PP
FFFFFFFFFFFF  MM        MM   SSSSSSSSSS   CCCCCCCCCC   HH        HH  AA        AA  PP


 CCCCCCCCC   LL            AAAAAAAAAA   SSSSSSSSSS   SSSSSSSSSS
CCCCCCCCCCC  LL           AAAAAAAAAAAA  SSSSSSSSSSS  SSSSSSSSSSS
CC       CC  LL           AA        AA  SS        SS  SS        SS
CC           LL           AA        AA  SS            SS
CC           LL           AA        AA  SSS           SSS
CC           LL           AAAAAAAAAAAA   SSSSSSSSS    SSSSSSSSS
CC           LL           AAAAAAAAAAAA    SSSSSSSSS   SSSSSSSSS
CC           LL           AA        AA            SSS           SSS
CC           LL           AA        AA             SS            SS
CC       CC  LL           AA        AA  SS        SS  SS        SS
CCCCCCCCCCC  LLLLLLLLLLLL AA        AA  SSSSSSSSSSS   SSSSSSSSSSS
 CCCCCCCCC   LLLLLLLLLLLL AA        AA   SSSSSSSSSS    SSSSSSSSSS
```

Produced Fall 1997

Local • NAU (Flagstaff)
• NORTH (Phoenix)

Subject
Production
Chris
Carol

Lucille
Gordon

```
//EMSCHAP JOB CLASS=C,MSGLEVEL=(1,1),MSGCLASS=A
//EMSCHAP EXEC PGM=IEYFORT,REGION=100K
//SYSPRINT DD SYSOUT=A
//SYSPUNCH DD SYSOUT=B
//SYSLIN DD DSNAME=&LOADSET,DISP=(MOD,PASS),UNIT=SYSSQ,
//  SPACE=(80,(200,100),RLSE),DCB=BLKSIZE=80
//FORT.SYSIN DD *
IEF236I ALLOC. FOR EMSCHAP  FORT
IEF237I 103   ALLOCATED TO SYSLIN
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS75339.T191319.RF102.EMSCHAP.LOADSET        PASSED
IEF285I   VOL SER NOS= PR0001.
//LKED EXEC PGM=IEWL,REGION=96K,PARM=(XREF,LIST,LET),COND=(4,LT,FORT)
//SYSLIB DD DSNAME=SYS1.FORTLIB,DISP=SHR
//SYSLMOD DD DSNAME=&GOSETMAINT,DISP=(NEW,PASS),UNIT=SYSSQ,
//  SPACE=(1024,(20,10,1),RLSE),DCB=BLKSIZE=1024
//SYSPRINT DD SYSOUT=A
//SYSUT1 DD UNIT=SYSSQ,SPACE=(1024,(100,10),RLSE),DCB=BLKSIZE=1024,
//  DSNAME=&SYSUT1
//SYSLIN DD DSNAME=&LOADSET,DISP=(OLD,DELETE)
//  DD DDNAME=SYSIN
IEF236I ALLOC. FOR EMSCHAP  LKED
IEF237I 100   ALLOCATED TO SYSLIB
IEF237I 103   ALLOCATED TO SYSLMOD
IEF237I 103   ALLOCATED TO SYSUT1
IEF237I 103   ALLOCATED TO SYSLIN
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS1.FORTLIB                                  KEPT
IEF285I   VOL SER NOS= SYSRES.
IEF285I   SYS75339.T191319.RF102.EMSCHAP.GOSET          PASSED
IEF285I   VOL SER NOS= PR0002.
IEF285I   SYS75339.T191319.RF102.EMSCHAP.SYSUT1         DELETED
IEF285I   VOL SER NOS= PR0002.
IEF285I   SYS75339.T191319.RF102.EMSCHAP.LOADSET        DELETED
IEF285I   VOL SER NOS= PR0001.
//GO EXEC PGM=*.LKED.SYSLMOD,COND=((4,LT,FORT),(4,LT,LKED))
//GO.FT02F001 DD DSN=EMS.NOMAT4,UNIT=SYSSQ,DISP=OLD
//GO.FT03F001 DD DSN=EMS.CHARCC,UNIT=SYSSQ,DISP=(MOD,KEEP)
//GO.FT04F001 DD DSN=EMS.CHAMAA,UNIT=SYSSQ,DISP=(MOD,KEEP)
//GO.FT06F001 DD SYSOUT=C,,B510
//GO.FT05F001 DD *
IEF236I ALLOC. FOR EMSCHAP  GO
IEF237I 103   ALLOCATED TO PGM=*.DD
IEF237I 101   ALLOCATED TO FT02F001
IEF237I 101   ALLOCATED TO FT01F001
IEF237I 101   ALLOCATED TO FT03F001
IEF237I 101   ALLOCATED TO FT06F001
IEF142I - STEP WAS EXECUTED - COND CODE 0016
IEF285I   SYS75339.T191319.RF102.EMSCHAP.GOSET          PASSED
IEF285I   VOL SER NOS= PR0002.
IEF285I   EMS.VAMM                                      KEPT
IEF285I   VOL SER NOS= RESLIB.
IEF285I   EMS.NOMAT4                                    KEPT
IEF285I   VOL SER NOS= RESLIB.
IEF285I   EMS.CHARCC                                    KEPT
IEF285I   VOL SER NOS= RESLIB.
IEF285I   EMS.CHAMAA                                    KEPT
IEF285I   VOL SER NOS= RESLIB.
IEF285I   SYS75339.T191319.RF102.EMSCHAP.GOSET          DELETED
```

IEF235I VOL SER NOS= PRD002.
IEF238I FMSCHAP SYSOUT=A,C.

```
0001          LOGICAL*1 MCASE(20),ADD(26)
0002          INTEGER NAME(22),BLK/' '/,COM/','/
0003          INTEGER FNAME(22)
0004          LOGICAL*1 Z/'Z'/
0005          INTEGER Y/'Y'/
0006          INTEGER STATUS
0007          INTEGER BLANK/'  '/
0008          INTEGER MM,YY,AGE,MO,DA,YR,VMO,VDA,VYR
0009          INTEGER AMO,ADA,AYR
0010          REAL*8 MED(
0011          INTEGER ICD1(3),ICD2(3)
0012          LOGICAL*1 (CDA(109,30)
0013          INTEGER SEX,ONE/'1'/,TWO/'2'/,MALE/'M'/,FEM/'F'/
0014          READ(5,31) (NV
0015       31 FORMAT(I4)
0016          DO 99 K=1,109
0017          READ(5,30) ((CDA(K,I),I=1,30)
0018       30 FORMAT(4X,30A1)
0019       99 CONTINUE
0020          READ(5,22) MO,DA,YR
0021       22 FORMAT(3I2)
0022          DO 100 K=1,1088
0023          READ(1,40) MID,MED(,(MCASE(I),I=1,20),(NAME(I),(=1,22),
              A(ADD(I),(=1,20),SEX,MM,YY,APT
0024       40 FORMAT(I6,A7,20A1,5X,22A1,8X,20A1,26X,A1,2X,I2,2X,I2,117X,A3)
0025          IF(SEX.EQ.ONE) SEX=MALE
0026          IF(SEX.EQ.TWO) SEX=FEM
0027          IF(MM.GT.MO) YY=YY+1
0028          AGE=YR-YY
0029      200 CONTINUE
0030          READ(2,41) ID,VMO,VDA,VYR,(ICD1(I),I=1,3)
0031          READ(2,41) ID,AMO,ADA,AYR,(ICD2(I),I=1,3)
0032       41 FORMAT(1X,I6-3I2,5X,3I3)
0033          IF(ID.NE.(0) GO TO 200
0034          WRITE(6,5)
0035       51 FORMAT(20X,'THE CITY OF NEW YORK'/20X,'DEPARTMENT OF SOCIAL SERVIC
              ES'/20X,'CHILD HEALTH ASSURANCE PROGRAM'/
              A20X,'305 BROADWAY (330 FLOOR)'/
              220X,'NEW YORK, N.Y. 10007')
0036          WRITE(6,1) FMV,(NAME(I),I=1,20),SEX,MM,YY
0037          WRITE(6,2) MED(,(MCASE(I),I=1,19),(ADD(I),(=1,25),APT
0038          WRITE(6,3) AGE,MO,DA,YR
0039          WRITE(6,4) VMO,VDA,VYR,AMO,ADA,AYR
0040          WRITE(6,7)
0041        7 FORMAT(//5X,'DIAGNOSIS   (CDA',20X,'DIAGNOSIS   (CDA')
0042          IF(ICD1(1).LT.1.OR.(CD1(1).GT.108.AND.(VMO.EQ.AMO.AND.VYR.EQ.AYR))
              AICD1(1)=(CD2(1)
0043          IF(ICD2(1).LT.1.OR.(CD2(1).GT.108.AND.(VMO.EQ.AMO.AND.VYR.EQ.AYR))
              AICD2(1)=(CD1(1)
0044          IF(ICD1(1).LT.1.OR.(CD1(1).GT.108) ICD1(1)=103
0045          IF(ICD2(1).LT.1.OR.ICD2(1).GT.108) ICD2(1)=103
0046          DO 99 L=1,3
0047          IF(ICD1(L).LT.1.OR.(CD1(L).GT.108) ICD1(L)=109
0048          IF(ICD2(L).LT.1.OR.(CD2(L).GT.108) (CD2(L)=109
```

```
      I1=ICD1(L)
      I2=ICD2(L)
      WRITE(6,5) (ICDA(I1,I),I=1,30),(ICDA(I2,I),I=1,30)
    5 FORMAT(10X,30A1,10X,30A1)
      IF(ICD1(L).EQ.109) ICD1(L)=0
      IF(ICD2(L).EQ.109) ICD2(L)=0
   90 CONTINUE
      WRITE(6,8)
    8 FORMAT(/5X,'CONDITION TREATED BY',16X,'CONDITION TREATED BY'/
     15X,'REPORTING PROVIDER',18X,'REPORTING PROVIDER')
    1 FORMAT(//15X,'CHILD HEALTH CARE STATUS REPORT'///
     15X,'INVOICE NO',25X,'CLAIM CONTROL NO'/5X,'Z',I5///
     A10X,'PROVIDER ID',19X,'PATIENT ID'//
     21X,'PROVIDER ID NO',6X,'NAME',
     36X,'NAME (LAST FIRST)',5X,'SEX',1X,'BIRTH'/
     41X,'440196160',4X,'ROOSEVELT HOSP',3X,20A1,3X,A1,2X,I2,'/',I2)
    2 FORMAT(/3X,'ADDRESS',22X,'ID NO',6X,'CASE NAME'/
     )1X,'428 459 ST MAN NYC NY',9X,A8,4X,19A1//
     21X,'GROUP',1X,'PHONE',2X,'SPECIALTY',3X,'ADDRESS',20X,'APT'/
     36X,'5547475',1X,'PEDIATRICS',7X,26A1,1X,A3)
    3 FORMAT(/31X,'AGE',3X,'DELAYED  NO',3X,'SUPPORT  NO'/
     121X,I2,4X,'3RD PARTY ',4X,'REPORTS'////
     22X,'SERVICE',2X,'PLACE',2X,'DIAGNOSIS',2X,'SERVICE',3X,'NO',4X,
     3'AMT',5X,'DIM USE'/3X,'DATE',3X,'SERVICE',4X,'CODE',5X,'CODE',3X,
     4'UNITS',2X,'CLAIM',6X,'ONLY'//2X,'MODAYR',2X,'CD ZIP'/
     52X,3I2,2X,'4 10019',4X,'Y00.0',4X,'9008R',4X,'1.0',4X,'5.00'//
     618X,'TOTAL ENTRY LINES 1',5X,' 5.00  TOTAL AMOUNT'//)
    4 FORMAT(20X,'MEDICAL CARE STATUS'//10X,'YES'/2X,
     2'CHILD IS IN MY CONTINUING CARE, AND HAS HAD OR IS RECEIVING'/
     A2X,'THE NECESSARY PHYSICAL EXAMINATION, IMMUNIZATIONS, GROWTH AND'
     B/2X,'DEVELOPMENTAL EVALUATIONS AND LABORATORY TESTS FOR HIS AGE ',
     C'AND'/2X,'SEX.  WHERE APPROPRIATE, SICKLE CELL, ANEMIA, LEAD',
     D' POISONING'/2X,'TESTS AND RELATED LABORATORY WORK HAVE BEEN ',
     E'PERFORMED.'//
     3/5X,'LAST VISIT  MO DA YR',16X,'LAST EXAM  MO DA YR'/
     517X,I2,'/',I2,'/',I2,27X,I2,'/',I2,'/',I2)
      WRITE(6,6)
    6 FORMAT(/////1X)
      I1=0
      DO 79 J=1,22
      FNAME(J)=BLK
   79 CONTINUE
      DO 70 J=3,21
      IF(I1.NE.0) GO TO 71
      IF(NAME(J).EQ.BLK.OR.NAME(J).EQ.COM) I1=J
      GO TO 70
   71 IF(NAME(J).NE.BLK.AND.NAME(J).NE.COM) GO TO 70
      I2=J
      LEN=I2-I1
      IF(LEN.LT.3) GO TO 70
      IF(NAME(J+1).EQ.BLK.OR.NAME(J+2).EQ.BLK) GO TO 75
      I1=I2
   70 CONTINUE
   75 JJ=0
```

```
0080          J1=I1+1
0081          DO 76 J=J1,22
0082          JJ=JJ+1
0083          FNAME(JJ)=NAME(J)
0084       76 CONTINUE
0085          WRITE(3,800) Z,INV,MO,YR,(MCASE(I),I=1,20),MEDI,SEX,MM,YY,
             AFNAME(I),I=1,10)
0086      800 FORMAT(A1,I5,2I2,20A1,A8,3X,A1,2I2,10A1)
0087          STATUS=Y
0088          WRITE(4,801) Y,MID,(NAME(I),I=1,22),SEX,MM,YY,MEDI,
             AIMCASE(I),I=1,20),OME,Y,MID,(ADD(I),I=1,20),APT,MO,DA,YR,STATUS,
             BYMO,BDA,BYR,(ICD1(I),I=1,3),AMO,ADA,AYR,(ICD2(I),I=1,3),TNO
0089      801 FORMAT(A1,I6,22A1,3X,A1,2I2,A8,3X,20A1,11X,A1/
             AA1,I6,20A1,10X,A3,3I2,A1,3I2,3I3,3I2,3I3,2X,A1)
0090          INV=INV+1
0091      100 CONTINUE
0092          STOP
0093          END
```

SUBPROGRAMS CALLED

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
IRCOMB	158								

SCALAR MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MFOT	160	BLK	168	COM	16C	Y	170	BLANK	174
DIF	178	TWO	17C	MALB	180	FFM	184	NW	15A
K	18C	I	190	KO	194	DA	198	YR	17C
MID	1A0	SEX	1A4	MM	1A8	YY	1AC	APT	150
AGE	1B4	ID	1B8	VMO	1BC	VDA	1C0	VYR	1C4
AMO	1C8	ADA	1CC	AYR	1D0	L	1D4	II	1D8
I2	1DC	J	1E0	LEN	1E4	JJ	1E8	JI	1EC
STATUS	1F0	Z	1F4						

ARRAY MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MCASE	1F5	ADD	209	NAME	224	FNAME	27C	ICD1	2B4
ICD2	2F0	ICDA	2EC						

FORMAT STATEMENT MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
31	F82	30	F85	22	F8E	40	FC4	41	FEA
51	FEA	7	1085	5	1083	8	1CC9	1	1139
2	1211	3	1280	4	1357	6	157F	600	1586
801	1594								

```
*OPTIONS IN EFFECT*  NOID,EBCDIC,SOURCE,NOLIST,NODECK,LOAD,MAP
*OPTIONS IN EFFECT*  NAME = MAIN    , LINECNT =      56
*STATISTICS*    SOURCE STATEMENTS =        93,PROGRAM SIZE =      8734
*STATISTICS*  NO DIAGNOSTICS GENERATED
```

F64-LEVEL LINKAGE EDITOR OPTIONS SPECIFIED XREF,LIST,LET
DEFAULT OPTION(S) USED - SIZE=(120832,24576)

CROSS REFERENCE TABLE

CONTROL SECTION

NAME	ORIGIN	LENGTH
MAIN	00	221E
IHCFCOMH*	2220	C09
IHCFCOMH2*	2F00	434
IHCFCVTH*	3338	1190
IHCFINTH*	4408	39E
IHCFIOSH*	4878	100E
IHCUOPT *	5883	8
IHCTRCH *	5890	204
IHCUATBL*	5858	88

ENTRY

NAME	LOCATION	NAME	LOCATION	NAME	LOCATION	NAME	LOCATION
IBCOM#	2220	FDIOCS#	22DC	INTSWTCH	2EDE		
SEQDASD	3224						
ADCON#	3338	FCVAOUTP	33E2	FCVLOUTP	3472	FCVZOUTP	[illegible]
FCVIOUTP	3970	FCVFOUTP	3E72	FCVCOUTP	40BC	[illegible]	[illegible]
ARITH#	4408	ADJSWTCH	4790				
FIOCS#	4878						
IHCERRM	5890						

LOCATION	REFERS TO SYMBOL	IN CONTROL SECTION
158	IBCOM#	IHCFCOMH
2DE8	ADCON#	IHCFCVTH
2DEC	ARITH#	IHCFINTH
2DE3	IHCUOPT	IHCUOPT
2DE4	FCVLOUTP	IHCFCVTH
2DEC	FCVCOUTP	IHCFCVTH
2DE4	FCVZOUTP	IHCFCVTH
2DE4	IHCERRM	IHCTRCH
3196	IHCFCOMH	IHCFCOMH
2E44	IBCOM#	IHCFCOMH
4330	IHCERRM	IHCTRCH
4733	INTSWTCH	IHCFCOMH
4783	IHCUOPT	IHCUOPT
4780	FIOCS#	IHCFIOSH
5680	IHCUATBL	IHCUATBL
5618	IBCOM#	IHCFCOMH
5830	FIOCS#	IHCFIOSH

LOCATION	REFERS TO SYMBOL	IN CONTROL SECTION
22DC	SEQDASD	IHCCOMH
2DED	FIOCS#	IHCFIOSH
2DEC	ADJSWTCH	IHCFINTH
2DED	FCVFOUTP	IHCFCVTH
2DE3	FCVIOUTP	IHCFCVTH
2DE0	FCVAOUTP	IHCFCVTH
2DED	IHCFCOMH	IHCFCOMH
3139	IHCFCOMH	IHCFCOMH
2E48	IHCERRM	IHCTRCH
4334	IBCOM#	IHCFCOMH
4704	IBCOM#	IHCFCOMH
4780	INTSWTCH	IHCFCOMH
4780	ADCON#	IHCFCVTH
4930	IHCERRM	IHCTRCH
5680	IBCOM#	IHCFCOMH
5A8C	ADCON#	IHCFCVTH

ENTRY ADDRESS 00

TOTAL LENGTH 58E0
[illegible] DOES NOT EXIST BUT HAS BEEN ADDED TO DATA SET
[illegible] CODE IS 0.

```
FFFFFFFFFFF  MM        MM   SSSSSSSSSS    CCCCCCCCCC    PPPPPPPPPPP    2222222222
FFFFFFFFFFF  MMM      MMM  SSSSSSSSSSSS  CCCCCCCCCCCC  PPPPPPPPPPPP  222222222222
FF           MMMM    MMMM  SS        SS  CC        CC  PP        PP  22        22
FF           MM MM  MM MM  SS            CC            PP        PP            22
FF           MM  MMMM  MM  SSS           CC            PP        PP            22
FFFFFFFF     MM   MM   MM   SSSSSSSSS    CC            PPPPPPPPPPP           22
FFFFFFFF     MM        MM    SSSSSSSSS   CC            PPPPPPPPPPP        22
FF           MM        MM           SSS  CC            PP                22
FF           MM        MM            SS  CC            PP              22
FF           MM        MM  SS        SS  CC        CC  PP            22
FFFFFFFFFFF  MM        MM  SSSSSSSSSSSS  CCCCCCCCCCCC  PP          222222222222
FFFFFFFFFFF  MM        MM   SSSSSSSSSS    CCCCCCCCCC    PP          222222222222

 CCCCCCCCCC   LL            AAAAAAAAAA    SSSSSSSSSS    SSSSSSSSSS
CCCCCCCCCCCC  LL           AAAAAAAAAAAA  SSSSSSSSSSSS  SSSSSSSSSSSS
CC        CC  LL           AA        AA  SS        SS  SS        SS
CC            LL           AA        AA  SS            SS
CC            LL           AA        AA  SSS           SSS
CC            LL           AAAAAAAAAAAA   SSSSSSSSS     SSSSSSSSS
CC            LL           AAAAAAAAAAAA    SSSSSSSSS     SSSSSSSSS
CC            LL           AA        AA           SSS          SSS
CC            LL           AA        AA            SS           SS
CC        CC  LL           AA        AA  SS        SS  SS        SS
CCCCCCCCCCCC  LLLLLLLLLLLL  AA        AA  SSSSSSSSSSSS  SSSSSSSSSSSS
 CCCCCCCCCC   LLLLLLLLLLLL  AA        AA   SSSSSSSSSS    SSSSSSSSSS
```

Produced
CORP [illegible]

input CORP

```
//EMSCP2 JOB CLASS=C,TIME=1440
//TEST EXEC PGM=IEWTEST,REGION=100K
//SYSPRINT DD SYSOUT=A
//SYSPUNCH DD SYSOUT=B
//SYSLIN DD DSNAME=SLOADSET,DISP=(MOD,PASS),UNIT=SYSSQ,
//   SPACE=(80,(200,100),RLSE),DCB=BLKSIZE=80
//SYSIN DD *
IEF237I ALLOC. FOR EMSCP2   FORT
IEF237I 100   ALLOCATED TO SYSLIN
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS76210.T105941.RF103.EMSCP2.LOADSET          PASSED
IEF285I   VOL SER NOS= 800002.
//LKED EXEC PGM=IEWL,REGION=96K,PARM=(XREF,LET,LIST),COND=(4,LT,FORT)
//SYSLIB DD DSNAME=SYS1.FORTLIB,DISP=SHR
//SYSLMOD DD DSNAME=GOOSET(MAIN),DISP=(NEW,PASS),UNIT=SYSSQ,
//   SPACE=(1024,(20,10,1),RLSE),DCB=BLKSIZE=1024
//SYSPRINT DD SYSOUT=A
//SYSUT1 DD UNIT=SYSSQ,SPACE=(1024,(100,10),RLSE),DCB=BLKSIZE=1024,
//   DSNAME=&&SYSUT1
//SYSLIN DD DSNAME=SLOADSET,DISP=(OLD,DELETE)
//   DD DDNAME=SYSIN
IEF237I ALLOC. FOR EMSCP2   LKED
IEF237I 100   ALLOCATED TO SYSLIB
IEF237I 102   ALLOCATED TO SYSLMOD
IEF237I 103   ALLOCATED TO SYSUT1
IEF237I 102   ALLOCATED TO SYSLIN
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS1.FORTLIB                                   KEPT
IEF285I   VOL SER NOS= SYS085.
IEF285I   SYS76210.T105941.RF103.EMSCP2.GOSET            PASSED
IEF285I   VOL SER NOS= 800002.
IEF285I   SYS76210.T105941.RF103.EMSCP2.SYSUT1           DELETED
IEF285I   VOL SER NOS= 800002.
IEF285I   SYS76210.T105941.RF103.EMSCP2.LOADSET          DELETED
IEF285I   VOL SER NOS= 800002.
//GO EXEC PGM=GOOSET,SYSLMOD,COND=(14,LT,FORT),(4,LT,LKED)
//GO.FT06F001 DD DSN=SYS.DUMP2,UNIT=SYSSQ,DISP=SHR
//GO.FT05F001 DD SYSOUT=(C,,RSI0)
//GO.FT08F001 DD *
IEF237I ALLOC. FOR EMSCP2   GO
IEF237I 103   ALLOCATED TO DSN=*.GO
IEF237I 101   ALLOCATED TO FT06F001
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS76210.T105941.RF103.EMSCP2.GOSET            PASSED
IEF285I   VOL SER NOS= 800002.
IEF285I   SYS1.DUMP2                                     KEPT
IEF285I   VOL SER NOS= 255L10.
IEF285I   SYS76210.T105941.RF103.EMSCP2.GOSET            DELETED
IEF285I   VOL SER NOS= 800002.
IEF285I   SYSOUT=A,C.
```

```
      INTEGER AZ,INVA,MOA,YRA,MCASE(20),SEX,MM,YY,FNAME(10)
      REAL*8 MEDI
      INTEGER M1,D1,Y1,M2,D2,Y2
      INTEGER P1,PT
      INTEGER TOT
      READ(5,71) P1,PT
   71 FORMAT(2I3)
      READ(5,70) INV
   70 FORMAT(I6)
      READ(5,72) M1,D1,Y1,M2,D2,Y2
   72 FORMAT(3I2,3I2)
      READ(5,73) TOT
   73 FORMAT(I4)
      READ(5,75) INV1
   75 FORMAT(I6)
      DO 300 J=1,4
      WRITE(6,51)
   51 FORMAT(20X,'THE CITY OF NEW YORK'/20X,
     A'CHILD HEALTH ASSURANCE PROGRAM'/20X,
     1'DEPARTMENT OF SOCIAL SERVICES'/20X,
     2'305 BROADWAY (2ND FLOOR)'/20X,'NEW YORK, N.Y. 10007'/
      WRITE(6,1) INV,P1,PT,M1,D1,Y1,M2,D2,Y2
    1 FORMAT(/25X,'SUMMARY CLAIM SHEET'/5X,'PAGE 1 OF 2'//
     15X,'INVOICE NO',25X,'CLAIM CONTROL NO'/
     45X,'Z',I6//
     22X,'PROVIDER ID NO',3X,'NAME',15X,'ADDRESS'/
     35X,'440196160',7X,'ROOSEVELT HOSP',5X,'428 W 59 ST NYC, NY'//
     42X,'PERIOD COVERED',15X,'PAGE',I3,' OF',I4,' PAGES'/
     52X,'MO DA YR TO MO DA YR'/2X,I2,1X,I2,1X,I2,4X,I2,1X,I2,1X,I2/)
      INV2=INV1+PT-1
      WRITE(6,5) INV1,INV2,TOT
    5 FORMAT(2X,'INVOICE NOS FOR SUMMARY CLAIM SHEETS'/5X,'Z',I6,' - ',
     8'Z',I6//2X,'TOTAL NO OF CLAIMS',I7)
      WRITE(6,23)
   23 FORMAT(/1X)
      WRITE(6,2)
    2 FORMAT(1X,'LN',2X,'INVOICE',2X,'SERV',2X,'CASE NAME',2X,
     1'PATIENT',2X,'S',1X,'BIRTH',2X,'FIRST',2X,'TOTAL',2X,'CHAR',
     3/1X,'NO',1X,'    NO    ',2X,'DATE',14X,'ID NO',3X,'F',1X,
     4'DATE',3X,'NAME',3X,'DOLLAR',1X,'USE'/
     540X,'K',15X,'CLAIM',2X,'ONLY')
      DO 100 K=1,25
      READ(4,200,END=201) AZ,INVA,MOA,YRA,MCASE(I),I=1,20),MEDI,SEX,
     AMM,YY,(FNAME(I),I=1,10)
  200 FORMAT(A1,I6,2I2,20A1,A8,3X,A1,2I2,10A1)
      WRITE(6,11) K,AZ,(INVA,MOA,YRA,(MCASE(I),I=1,10),MEDI,
     ASEX,MM,YY,(FNAME(I),I=1,7)
   11 FORMAT(1X,I2,2X,A1,I6,1X,I2,'/',I2,1X,10A1,1X,A8,2X,A1,1X,I2,'/',
     AI2,1X,7A1,1X,' 5.00')
  100 CONTINUE
      GO TO 203
  201 CONTINUE
      DO 202 L=K,25
      WRITE(6,12) L
```

```
   12 FORMAT(1X,I2)
  200 CONTINUE
  201 CONTINUE
      WRITE(6,10)
   10 FORMAT(/2X,'REVIEWED BY',9X,'AUTHORIZED BY',
     119X,'125.00 ','COMPLETED'/
     260X,'TOTAL'/60X,'CLAIMED'//
     35X,'NO VALID CLAIMS ___',35X,'ADJUSTMENTS'//60X,'CHECK FOR'/
     460X,'THIS AMT')
      WRITE(6,19) INV
   19 FORMAT(/////5X,'INVOICE NO'/3X,'2',I6,//5X,'PAGE 2 OF 2'/////1X)
      WRITE(6,20)
   20 FORMAT(1X,'AFFIDAVIT:  I CERTIFY THAT THE CARE, SERVICES AND',
     7' SUPPLIES'/1X,'ITEMIZED HAVE BEEN FURNISHED; THE AMOUNTS LISTED',
     1' ARE DUE'/1X,'AND, EXCEPT AS NOTED, NO PART THEREOF HAS BEEN',
     2' PAID. PAYMENT'/1X,'OF FEES AND RATES MADE IN ACCORDANCE WITH',
     3' ESTABLISHED SCHEDULES'/
     4'1X,'IS ACCEPTED AS PAYMENT IN FULL; AND THERE HAS BEEN',
     5' COMPLIANCE WITH'/1X,'TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT',
     6' OF 1964 WITHOUT DISCRIMINATION'/1X,'ON THE BASIS OF RACE,',
     7' COLOR OR NATIONAL ORIGIN. I AGREE TO KEEP'/1X,'SUCH RECORDS',
     8' AS ARE NECESSARY OF SUCH ITEMIZED CARE, SERVICES AND'/
     9'1X,'SUPPLIES WHICH I HAVE PROVIDED AND TO FURNISH INFORMATION'/
     A1X,'REGARDING ANY PAYMENTS CLAIMED THEREFOR AS THE LOCAL SOCIAL')
      WRITE(6,21)
   21 FORMAT(1X,'SERVICES AGENCY OR THE STATE DEPARTMENT OF SOCIAL ',
     A'SERVICES'/
     11X,'MAY REQUEST. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF'/
     21X,'THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS'
     3/1X,'AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND'/
     41X,'STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR'/
     51X,'CONCEALMENT OF A MATERIAL FACT.'//1X,'PROVIDERS SIGNATURE',
     61X,'DATE (MO DA YR)'//)
      WRITE(6,22)
   22 FORMAT(////////////////////////////1X)
      WRITE(6,24)
   24 FORMAT(//////////1X)
      INV=INV+1
      P1=P1+1
  300 CONTINUE
      STOP
      END
```

SUBPROGRAMS CALLED

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
IBCOM#	0C								

SCALAR MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MEDI	C0	P1	C8	PT	CC	INV	D0	M1	D4
P1	D8	Y1	DC	M2	E0	D2	E4	Y2	E8
TOT	EC	INV1	F0	J	F4	INV2	F8	K	FC
AT	100	INVA	104	MOA	108	YOA	10C	I	11
SEX	114	MM	118	XY	11C	L	130		

ARRAY MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MCLSE	124	ENAME	174						

FORMAT STATEMENT MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
71	19C	70	142	72	146	73	132	75	1[illegible]4
51	1[illegible]8	1	240	5	361	23	387	2	33C
200	478	11	494	12	4CF	10	405	1[illegible]	5[illegible]7
20	39C	21	849	22	9DC	24	9E0		

OPTIONS IN EFFECT NOID,EBCDIC,SOURCE,NOLIST,NODECK,LOAD,MAP
OPTIONS IN EFFECT NAME = MAIN , LINECNT = 56
STATISTICS SOURCE STATEMENTS = 57,PROGRAM SIZE = 3702
STATISTICS NO DIAGNOSTICS GENERATED

```
E44-LEVEL LINKAGE EDITOR OPTIONS SPECIFIED XREF,LET,LIST
        DEFAULT OPTION(S) USED -  SIZE=(120832,24576)

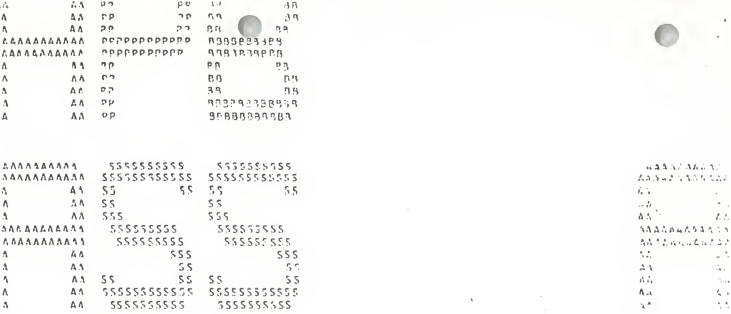

                                CROSS REFERENCE TABLE

CONTROL SECTION                                 ENTRY

  NAME...ORIGIN  LENGTH ..... ..... NAME . LOCATION .... NAME . LOCATION.... NAME . LOCATION ... NAME . LOCATION
MAIN        00      576
IHCFCOMM   0240      004
                                                 IBCOM#      0240    CBIOCS#     0244    INTSWITCH   1A38
IHCCOMH#   0258      034
                                                 SEQDASD     1E42
IHCECVTH   0300     1100
                                                 AMCOM#      1E00    EVMAGBIP    2036    EVEVLIP     2040    EVMTIMER    2044
                                                 EOVIOUTP    2054    EOVEOUTP    2060    EOVCOUTP    2064    EOVTCATCH   2068
IHCFINTH   3120     0F8
                                                 ABITH#      3130    ADJSWITCH   3380
IHCFIOSH   3400     1006
                                                 CIOCS#      3400
IHCUPDT    4408        3
IHCATCH    4404      004
                                                 IHCFCARM    44E0
IHCUSTBL   4700       88


LOCATION  REFERS TO SYMBOL  IN CONTROL SECTION.... ..... LOCATION  REFERS TO SYMBOL  IN CONTROL SECTION
    FE          IHCFCOMM        IHCFCOMM                  F24         SEQDASD         IHCFCOMM
  1A60          IBCOM#          IHCECVTH                  1A38        CIOCS#          IHCFIOSH
  1A46          ABITH#          IHCFINTH                  1A64        ADJSWITCH       IHCFINTH
  1A60          IHCUPDT         IHCECVTH                  1A48        EOVEOUTP        IHCECVTH
  1A60          EOVEOUTP        IHCECVTH                  1A60        EOVIOUTP        IHCECVTH
  1A64          EOVCOUTP        IHCECVTH                  1A58        EOVTCATCH       IHCECVTH
  1A60          EOVIOUTP        IHCECVTH                  1A18        IHCCOMH         IHCCOMH
  1A10          IHCFCARM        IHCTRCH                   1D61        IHCECOMM        IHCECOMM
  1D64          IHCECOMM        IHCECOMM                  1D40        IHCFCARM        IHCFCOMM
  1D60          IBCOM#          IHCECOMM                  2E02        IOCOM#          IHCECOMM
  2C00          IHCFCARM        IHCTRCH                   3422        IHCCOMH         IHCCOMH
  3420          INTSWITCH       IHCECOMM                  33E4        INTSWITCH       IHCECOMM
  3700          IHCUPDT         IHCUPDT                   3438        AMCOM#          IHCECVTH
  3436          CIOCS#          IHCFINTH                  3600        IHCFCARM        IHCFCOMM
  3408          IHCUATBL        IHCUATBL                  4316        IBCOM#          IHCECOMM
  44E0          IBCOM#          IHCECOMM                  4654        AMCOM#          IHCECOMM
  46F8          CIOCS#          IHCFIOSH
ENTRY ADDRESS.... ....00

 TOTAL LENGTH      4B93
IHCMAIN      DOES NOT EXIST BUT HAS BEEN ADDED TO DATA SET.... ... ....
WARNING CODE IS          0.
```



```
CC        CC  HH        HH  AA        AA  PP        PP  BB        BB
CC        CC  HH        HH  AA        AA  PP        PP  BB        BB
CC        CC  HH        HH  AA        AA  PP        PP  BB        BB
CC        CC  HHHHHHHHHHHH  AAAAAAAAAAAA  PPPPPPPPPPPP  BBBBBBBBBB
CC        CC  HHHHHHHHHHHH  AAAAAAAAAAAA  PPPPPPPPPPPP  BBBBBBBBBB
CC        CC  HH        HH  AA        AA  PP            BB        BB
CC        CC  HH        HH  AA        AA  PP            BB        BB
CC        CC  HH        HH  AA        AA  PP            BB        BB
CCCCCCCCCCCC  HH        HH  AA        AA  PP            BBBBBBBBBBBB
 CCCCCCCCCC   HH        HH  AA        AA  PP            BBBBBBBBBBB

 CCCCCCCCCC   LL            AAAAAAAAAA    SSSSSSSSSS    SSSSSSSSSS
CCCCCCCCCCCC  LL           AAAAAAAAAAAA  SSSSSSSSSSSS  SSSSSSSSSSSS
CC        CC  LL           AA        AA  SS        SS  SS        SS
CC            LL           AA        AA  SS            SS
CC            LL           AA        AA  SSS           SSS
CC            LL           AAAAAAAAAAAA   SSSSSSSSS     SSSSSSSSS
CC            LL           AAAAAAAAAAAA    SSSSSSSSS     SSSSSSSSS
CC            LL           AA        AA          SSS           SSS
CC            LL           AA        AA           SS            SS
CC        CC  LL           AA        AA  SS        SS  SS        SS
CCCCCCCCCCCC  LLLLLLLLLLLL  AA        AA  SSSSSSSSSSSS  SSSSSSSSSSSS
 CCCCCCCCCC   LLLLLLLLLLLL  AA        AA   SSSSSSSSSS    SSSSSSSSSS
```

sample of facsimile & CHAP W294B

```
//CHAP  JOB, CLASS=C
//FORT EXEC PGM=IEYFORT,REGION=100K
//SYSPRINT DD SYSOUT=A
//SYSPUNCH DD SYSOUT=B
//SYSLIN DD DSNAME=&LOADSET,DISP=(MOD,PASS),UNIT=SYSSQ,
//  SPACE=(80,(200,100),RLSE),DCB=BLKSIZE=80
//FORT.SYSIN DD *
IEF236I ALLOC. FOR CHAPB    FORT
IEF237I ICB   ALLOCATED TO SYSLIN
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS76021.T022219.RE103.CHAPB.LOADSET          PASSED
IEF285I   VOL SER NOS= PP0002.
//LKED EXEC PGM=IEWL,REGION=96K,PARM=(XREF,LIST,LET),COND=(4,LT,FORT)
//SYSLIB DD DSNAME=SYS1.FORTLIB,DISP=SHR
//SYSLMOD DD DSNAME=&GOSET(MAIN),DISP=(NEW,PASS),UNIT=SYSSQ,
//  SPACE=(1024,(20,10,1),RLSE),DCB=BLKSIZE=1024
//SYSPRINT DD SYSOUT=A
//SYSUT1 DD UNIT=SYSSQ,SPACE=(1024,(100,101),RLSE),DCB=BLKSIZE=1024,
//  DSNAME=&SYSUT1
//SYSLIN DD DSNAME=&LOADSET,DISP=(OLD,DELETE)
//  DD  DDNAME=SYSIN
IEF236I ALLOC. FOR CHAPB    LKED
IEF237I ICB   ALLOCATED TO SYSLIB
IEF237I ICB   ALLOCATED TO SYSLMOD
IEF237I ICB   ALLOCATED TO SYSUT1
IEF237I ICB   ALLOCATED TO SYSLIN
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS1.FORTLIB                                  KEPT
IEF285I   VOL SER NOS= SYS002.
IEF285I   SYS76021.T022219.RE103.CHAPB.GOSET            PASSED
IEF285I   VOL SER NOS= PP0001.
IEF285I   SYS76021.T022219.RE103.CHAPB.SYSUT1           DELETED
IEF285I   VOL SER NOS= PP0001.
IEF285I   SYS76021.T022219.RE103.CHAPB.LOADSET          DELETED
IEF285I   VOL SER NOS= PP0002.
//GO EXEC PGM=*.LKED.SYSLMOD,COND=((4,LT,FORT),(4,LT,LKED))
//GO.IEF069DI DD SYSOUT=(*,,,)
//GO.FT05F001 DD *
IEF236I ALLOC. FOR CHAPB    GO
IEF237I ICB   ALLOCATED TO PGM=*.DD
IEF142I - STEP WAS EXECUTED - COND CODE 0000
IEF285I   SYS76021.T022219.RE103.CHAPB.GOSET            PASSED
IEF285I   VOL SER NOS= PP0001.
IEF285I   SYS76021.T022219.RE103.CHAPB.GOSET            DELETED
IEF285I   VOL SER NOS= PP0001.
IEF209I  CHAPB    SYSOUT=A,C.
```

```
0001          REAL*8 MEDI
0002          INTEGER BOR,GRADE,AGE
0003          INTEGER ADD(26)
0004          INTEGER A(20)
0005          INTEGER NAME(20),MCASE(20)
0006          INTEGER IMM(5)
0007          REAL*8 SCH
0008          READ(5,51) INV
0009       51 FORMAT(I6)
0010          READ(5,20) (NAME(I),I=1,22),SEX,MM,YR
0011       20 FORMAT(22A1,A1,2I2)
0012          READ(5,21) MEDI,(MCASE(I),I=1,19),(ADD(I),I=1,26),APT
0013       21 FORMAT(A8,19A1,26A1,A1)
0014          READ(5,25) SCH,BOR,GRADE,AGE
0015       25 FORMAT(A8,A3,A2,I2)
0016          READ(5,60) (A(I),I=1,20)
0017       60 FORMAT(20A1)
0018          READ(5,500) (IMM(I),I=1,5)
0019      500 FORMAT(5A1)
0020          DO 100 K=1,4
0021          WRITE(6,52)
0022       52 FORMAT(20X,'THE CITY OF NEW YORK'/
             120X,'DEPARTMENT OF SOCIAL SERVICES'/
             220X,'CHILD HEALTH ASSURANCE PROGRAM'/
             320X,'305 BROADWAY (3RD FLOOR)'/
             420X,'NEW YORK, N.Y. 10007')
0023          WRITE(6,50)
0024       50 FORMAT(//(X)
0025          WRITE(6,1) INV,(NAME(I),I=1,20),SEX,MM,YR
0026          WRITE(6,2) MEDI,(MCASE(I),I=1,19),(ADD(I),I=1,26),APT
0027        1 FORMAT(15X,'PERIODIC CHILD HEALTH EXAMINATION'/20X,'REPORT AND ',
             1'CLAIM FORM'///5X,'PAGE 1 OF 3'//5X,'INVOICE NO',25X,
             A'CLAIM CONTROL NO'/
             25X,'3',I5///10X,'PROVIDER ID',19X,'PATIENT ID'//
             31X,'PROVIDER ID NO',4X,'NAME',
             46X,'NAME (LAST FIRST)',5X,'SEX',1X,'BIRTH'/
             51X,'440196160',4X,'ROOSEVELT HOSP',3X,20A1,3X,A1,2X,I2,'/',I2)
0028        2 FORMAT(/3X,'ADDRESS',22X,'ID NO',6X,'CASE NAME'/
             11X,'428 459 ST MAN NYC NY',9X,A8,4X,19A1//
             21X,'GROUP',1X,'PHONE',2X,'SPECIALTY',8X,'ADDRESS',20X,'APT'/
             36X,'5547475',1X,'PEDIATRICS',7X,26A1,1X,A1)
0029          WRITE(6,3) SCH,BOR,GRADE,AGE
0030        3 FORMAT(/31X,'SCHOOL',3X,'BOR','GRADE',3X,'AGE'/
             131X,A8,1X,A3,5X,A2,5X,I2//
             231X,'DELAYED  NO',4X,'SUPPORT  NO'/
             331X,'3RD PARTY',5X,'REPORTS'//////
             41X,'LN',2X,'SERVICE',2X,'PLACE',2X,'DIAGNOSIS',2X,'SERVICE',3X,
             5'NO',4X,'AMT',5X,'DIM USE'/5X,'DATE',3X,'SERVICE',4X,
             6'CODE',5X,'CODE',3X,'UNITS',2X,'CLAIM',6X,'ONLY'//
             75X,'MODAYR',2X,'CD 7IP'/
             81X,'101',1X,'120175',2X,'410019',4X,'Y00.0',6X,'7034',4X,'1.0',
             93X,'35.00')
0031          WRITE(6,58)
0032       58 FORMAT(//(X)
```

```
0033          WRITE(6,4)
0034        4 FORMAT(//5X,'CHILD IS OR WILL BE IN MY CONTINUING CARE',13X,'YES'/
            15X,'IS THIS THE FIRST PERIODIC HEALTH EXAM FOR THIS CHILD '/
            25X,'DURING THIS YEAR?',37X,'YES'//////)
0035          WRITE(6,36)
0036       36 FORMAT(//////1X)
0037          WRITE(6,30) INV
0038       30 FORMAT(5X,'PAGE 2 OF 3'//5X,'INVOICE NO'/5X,'R',16//
            A15X,'FINDINGS FROM HISTORY AND EXAMINATION'///
            02X,'CONDITIONS',15X,' N ',1X,'FURTHER',7X,' REFERRALS'/
            127X,' O ',1X,'MEDICAL',8X,'NAME OF'/
            227X,' R ',1X,'ATTENTION',4X,'CLINIC'/
            327X,' N ',1X,'SHOULD BEGIN',3X,'AND DATE'/
            427X,' A ',1X,'WITHIN',9X,'OF APPT'/
            527X,' L ',1X,' L ',1X,' 1 ',1X,'2-6'/
            630X,' NK',1X,' NO',1X,'YES'/)
0039          WRITE(6,7)
0040        7 FORMAT(2X,'1 HISTORY, 33OWTH',9X,'X'/
            12X,'   AND DEVELOPMENT'/
            22X,'2 SPEECH',18X,'X'/
            32X,'3A VISION',17X,'X'/
            42X,' B HEARING',14X,'X'/
            52X,'4 LAB TESTS PERFORMED')
0041          WRITE(6,8)
0042        8 FORMAT(2X,' A ANEMIA (HB OR HT)',6X,'X'/
            12X,' B URINALYSIS',13X,'X'/
            22X,' C SICKLE CELL (AS IND)',3X,'X'/
            32X,' D LEAD POISONING (AS IND)','X'/
            42X,' E TUBERCULIN',13X,'X'/
            52X,' F VDRL/GC (AS IND)',7X,'X')
0043          WRITE(6,31)
0044       31 FORMAT(2X,'6 PHYSICAL EXAMINATION'/
            12X,' A EYE',20X,'X'/
            22X,' B EAR',20X,'X'/
            32X,' C NOSE',19X,'X'/
            42X,' D MOUTH AND THROAT',7X,'X'/
            52X,' E DENTAL'/
            52X,'   SEEN IN LAST YEAR',6X,'N',18X,'12/15/75 ROOSEVELT'/
            72X,' F HEAD AND NECK',10X,'X')
0045          WRITE(6,32)
0046       32 FORMAT(2X,' G CARDIO-PULMONARY',7X,'X'/
            A5X,'HOP IS OVER 3 YEARS'/
            12X,' H ABDOMEN',16X,'X'/
            22X,' I GENITO-URINARY',9X,'X'/
            32X,' J MUSCULO-SKELETAL',3X,'X'/
            85X,'(INCLUDE POSTURE)'/
            42X,' K NEUROLOGICAL',11X,'X'/
            52X,' L CONDITION OF SKIN',5X,'X'/
            62X,' M BEHAVIOR',15X,'X'/
            62X,' N OTHER (SPECIFY)',3X,'X')
0047          WRITE(6,9) (IMMCI),I=1,5)
0048        9 FORMAT(//2X,'IMMUNIZATIONS',13X,'GIVEN',3X,'ADDITIONAL DOSES ',
            1'(REQUIRED)'/
            22X,'DPT',22X,'12/01/75',10X,A1/
```

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     32X,'POLIO',18X,'COMPLETE',10X,A1/
     J2X,'[illegible]SLES',16X,'HAD DISEASE',7X,A1/
     52X,'RUBELLA',16X,'NA',16X,A1/
     62X,'MUMPS',18X,'I2/01/75',10X,A1//)
      WRITE(6,10)
   10 FORMAT(5X,'ADDITIONAL INFORMATION   REMARKS:'//////1X)
      WRITE(6,37)
   37 FORMAT(/1X)
      WRITE(6,40) INV
   40 FORMAT(/////5X,'PAGE 3 OF 3'//5X,'INVOICE NO'/5X,'R',I6/////1X)
      WRITE(6,41)
   41 FORMAT(1X,'AFFIDAVIT:  I CERTIFY THAT THE CARE, SERVICES AND',
     7' SUPPLIES'/1X,'ITEMIZED HAVE BEEN FURNISHED: THE AMOUNTS LISTED',
     1' ARE DUE'/1X,'AND, EXCEPT AS NOTED, NO PART THEREOF HAS BEEN',
     2' PAID. PAYMENT'/1X,'OF FEES AND RATES MADE IN ACCORDANCE WITH',
     3' ESTABLISHED SCHEDULES'/
     41X,'IS ACCEPTED AS PAYMENT IN FULL; AND THERE HAS BEEN',
     5' COMPLIANCE WITH'/1X,'TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT',
     6' OF 1964 WITHOUT DISCRIMINATION'/1X,'ON THE BASIS OF RACE,',
     7' COLOR OR NATIONAL ORIGIN. I AGREE TO KEEP'/1X,'SUCH RECORDS',
     8' AS ARE NECESSARY OF SUCH ITEMIZED CARE, SERVICES AND'/
     91X,'SUPPLIES WHICH I HAVE PROVIDED AND TO FURNISH INFORMATION'/
     A1X,'REGARDING ANY PAYMENTS CLAIMED THEREFOR AS THE LOCAL SOCIAL')
      WRITE(6,42)
   42 FORMAT(1X,'SERVICES AGENCY OR THE STATE DEPARTMENT OF SOCIAL ',
     A'SERVICES'/
     11[illegible],'MAY REQUEST. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF'/
     2[illegible],'THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS'
     3[illegible],'AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND'/
     41X,'STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR'/
     51X,'CONCEALMENT OF A MATERIAL FACT.'//1X,'EXAM COMPLETED',
     615X,'DATE(MO DA YR)'//1X,'PROVIDERS SIGNATURE',10X,'DATE(MO DA YR)
     7'//)
      WRITE(6,43)
   43 FORMAT(//////////////////////////1X)
      WRITE(6,44)
   44 FORMAT(///1X)
      INV=INV+1
  100 CONTINUE
      STOP
      END
```

SUBPROGRAMS CALLED

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
IBCOM#	. BC								

SCALAR MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
MEDI	C0	SCH	C8	INV	D0	I	D4	SEX	[illegible]
MM	D0	YR	E0	ART	E4	BOR	E8	GRADE	[illegible]
AGE	F0	X	F4						

ARRAY MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
ADD	F8	A	160	NAME	130	MEASE	200	INV	[illegible]

FORMAT STATEMENT MAP

SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION	SYMBOL	LOCATION
51	266	20	268	21	274	25	282	40	[illegible]
500	292	52	293	50	320	1	334	2	[illegible]
2	4E8	58	637	6	63D	36	6D6	30	[illegible]
7	815	8	808	31	943	32	A0E	9	[illegible]
10	9CE	37	8EE	40	C03	41	C38	42	[illegible]
43	1000	44	100A						

OPTIONS IN EFFECT NOID,FREDIC,SOURCE,NOLIST,NODECK,LOAD,MAP
OPTIONS IN EFFECT NAME = MAIN , LINECNT = 56
STATISTICS SOURCE STATEMENTS = 66,PROGRAM SIZE = 5598
STATISTICS NO DIAGNOSTICS GENERATED

```
F64-LEVEL LINKAGE EDITOR OPTIONS SPECIFIED XREF,LIST,LET
        DEFAULT OPTION(S) USED - SIZE=(120832,243761)
```

CROSS REFERENCE TABLE

CONTROL SECTION

NAME	ORIGIN	LENGTH
MAIN	00	150E
IHCFCOMH*	15F0	0D9
IHCFCOMH2*	2200	434
IHCFCVTH*	2638	1190
IHCFINTH*	3898	39E
IHCFIOSH*	3C38	100E
IHCUPRT *	4C48	8
IHCTRCH *	4C50	274
IHCUATBL*	4E28	38

ENTRY

NAME	LOCATION	NAME	LOCATION	NAME	LOCATION	NAME	LOCATION
IHCDY#	15E0	FDIOCS#	1690	INTSWTCH	229E		
SEQDASD	25BA						
ADCON#	26F8	FCVADUTP	2742	FCVLOUTP	2832	FCVZOUTP	2982
FCVIOUTP	2030	FCVEOUTP	3232	FCVCOUTP	344C	INTESWCH	3733
ARITH#	3898	ADJSWTCH	3B50				
FIOCS#	3C38						
IHCERRM	4C50						

LOCATION	REFERS TO SYMBOL	IN CONTROL SECTION
0C	IHCDY#	IHCFCOMH
21A8	ADCON#	IHCFCVTH
21AC	ARITH#	IHCFINTH
21F8	IHCUPRT	IHCUPRT
2204	FCVLOUTP	IHCFCVTH
2230	FCVCOUTP	IHCFCVTH
2204	FCVZOUTP	IHCFCVTH
2194	IHCERRM	IHCTRCH
2540	IHCFCOMH	IHCFCOMH
2334	IRCDY#	IHCFCOMH
35F0	IHCERRM	IHCTRCH
3094	INTSWTCH	IHCFCOMH
3948	IHCUPRT	IHCUPRT
3B0C	FIOCS#	IHCFIOSH
4A70	IHCUATBL	IHCUATBL
4F40	IRCDY#	IHCFCOMH
4F50	FIOCS#	IHCFIOSH
ENTRY ADDRESS	00	

LOCATION	REFERS TO SYMBOL	IN CONTROL SECTION
159C	SEQDASD	IHCCOMH2
21A0	FIOCS#	IHCFIOSH
21CC	ADJSWTCH	IHCFINTH
2130	FCVEOUTP	IHCFCVTH
2138	FCVIOUTP	IHCFCVTH
2160	FCVADUTP	IHCFCVTH
2190	IHCCOMH2	IHCCOMH2
2549	IHCFCOMH	IHCFCOMH
2309	IHCERRM	IHCTRCH
3654	IRCDY#	IHCFCOMH
3094	IRCDY#	IHCFCOMH
3342	INTESWCH	IHCFCVTH
3BA0	ADCDY#	IHCFCVTH
3D70	IHCERRM	IHCTRCH
4A72	IRCDY#	IHCFCOMH
454C	ADCDY#	IHCFCVTH

```
TOTAL LENGTH      4F80
IHCFCOMH     DOES NOT EXIST BUT HAS BEEN ADDED TO DATA SET
AUTHORIZATION CODE IS        0.
```

APPENDIX B

CHAP W-294B PROTOCOL

Roosevelt Hospital
Modification of CHAP Procedures

CHAP (EPSDT) PROCEDURES PROTOCOL: ROOSEVELT HOSPITAL'S COMPREHENSIVE PEDIATRIC AMBULATORY CARE PROGRAM, 1976

I. PURPOSE OF THE CHAP PROGRAM

The 1967 amendments to Title XIX of the Social Security Act added a requirement to Medicaid that was intended to focus attention upon the importance of preventive health services and early detection and treatment of diseases in children eligible for medical assistance. This extension of the Title XIX Medicaid Program is commonly called the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) amendment.

In New York City the activities designed to carry out this mandate are encompassed in the Child Health Assurance Program (CHAP). It takes the form of the provision of continuous and comprehensive health care services to Medicaid eligible children up to age 21 and the assurance that this eligible pediatric population can enjoy access to a regular health care source.

Management of appointments and scheduling for periodic health examinations and needed treatment under CHAP is the responsibility of the health care provider as is verification of program eligibility. Since July 1975 the Roosevelt Hospital Pediatric Service has played an important role in CHAP as a major New York City provider. This role has entailed the establishment and maintenance

of an ongoing medical relationship with the catchment area and non-catchment area eligible pediatric populations. Roosevelt Hospital has actively demonstrated since that time its capabilities and willingness to respond to the preventive, episodic and acute health care needs of CHAP eligibles in an organized, coherent and humane fashion.

CHAP in no way conflicts with the basic mission and objectives of the Roosevelt Hospital Pediatric Service or the C&Y Program. The hospital's participation as a CHAP provider serves to enhance its role as a major health care provider and to indicate the continuing dedication of all the staff to high quality care for children.

II. CHAP FORMS AND THEIR FLOW

A. CHAP Forms W-294A and W-294C are the responsibility of the CHAP Medical Records Technician, (E. A ldridge). The CHAP Clinic Referral and Tracking Form is used by the New York City Child Health Assurance Program to refer patients who have requested CHAP services at Roosevelt Hospital and enables CHAP to provide immediate follow-up on cases failing to keep their initial CHAP examination appointments.

B. The original of the CHAP Clinic Referral and Tracking Form and two copies are sent to C&Y Administration. When initial CHAP appointments are scheduled, the appointment date is entered on the three copies of this form in columns 38 through 43 and copy number one returned to CHAP to provide them with Federally-required documentation that CHAP examinations are being offered on a timely basis. If an appointment cannot be arranged with the patient, the reason is indicated under "CHAP Provider's Comments" and copy number one forwarded to CHAP.

If the patient appears for the CHAP appointment, CHAP is notified by a circle placed around "Y" in column 44 on the form and the patient's clinic chart number is entered for reference. The original is retained by Roosevelt Hospital and copy number two forwarded to CHAP.

C. At the teams C&Y Contact Forms must be completed for patients with CHAP appointments in addition to the CHAP W-294B Form (described below).

D. The CHAP W-294B Form

In order to meet New York City and State reporting requirements for monitoring and planning and to be able to identify problems and subsequent treatment on an individual child basis throughout the extent of the EPSDT Program, it is necessary that a unique form - the CHAP W-294B - be completed for each CHAP-referred patient after each periodic examination.

This W-294B is a combined medical report and billing form to be filled out for all CHAP examinations. All procedures prescribed for the CHAP examination must be completed with results established before this form can be submitted for reimbursement. If a patient's illness at the time he or she appears for the CHAP examination prevents the performance of required procedures, the patient must be treated as he or she would be in a normal encounter and rescheduled for a CHAP examination as soon as possible.

CHAP W-294B INSTRUCTIONS (Consult sample form on following page)

1. Leave items 1 through 6 blank. These will be completed by the Medical Records Technician when she reviews the form.

2. Items 7 through 17 are to be completed by the team clerk or another team member at the time of the patient's CHAP appointment. Note the following: Item 10 (Medicaid Number) should be either seven or eight digits. Do not enter the three digit welfare center number here.

INSURED NO. A008001

NEW YORK, N.Y. 10001

PERIODIC CHILD HEALTH EXAMINATION REPORT AND CLAIM FORM

FOR D.I.M. USE ONLY

PROVIDER IDENTIFICATION

1. PROVIDER IDENT. NO.
2. NAME
3. OFFICE ADDRESS FROM WHICH SERVICES PROVIDED BOR. CITY STATE
4. GROUP NO.
5. TELEPHONE NO.
6. SPECIALTY

SERVICE CODES FOR THE BASIC PERIODIC EXAM ARE AS FOLLOWS:
ARTICLE 28 CLINICS 9034 | PRIVATE PHYSICIANS: PEDIATRICIAN 90088, INTERNIST 90088, GP/GEN. PRACT. 90089, OTHER 90086

PATIENT IDENTIFICATION

7. LAST NAME FIRST NAME M.I.
8. SEX M F
9. MO/YR OF BIRTH
10. IDENTIFICATION NUMBER
11. CASE NAME
12. ADDRESS CITY STATE
13. APT.
14. SCHOOL
15. BOROUGH
16. GRADE
17. AGE
18. DELAYED 3RD PARTY SUBMISSION Y N
19. SUPPORTING REPORTS ATTACHED? Y N

LINE NO.	20. SERVICE DATE MO.	DAY	YR.	21. PLACE SERVICE CD	ZIP	22. DIAGNOSIS CODE	23. SERVICE CODE	24. NO. OF UNITS	25. AMOUNT CLAIMED $ ¢	FOR DIM USE ONLY ADJ. CODE	ADJUSTED AMOUNT $ ¢
101						Y00.0		1.0			
102											
103											
104											
105											
106											

CLAIMS FOR ADDITIONAL SERVICES OR INFORMATION

☐ FORM W-303G ATTACHED FOR ADDITIONAL CHAP CLAIMS

TOT. NO. OF ENTRY LINES CLAIMED IN COLUMN 23 26.

TOTAL DOLLAR AMOUNT CLAIMED

Child is or will be in my continuing care ☐ YES ☐ NO

Is this the first Periodic Health Examination for this child during this year? ☐ YES ☐ NO

FINDINGS FROM HISTORY AND EXAMINATION

CONDITIONS	NORMAL	FURTHER MEDICAL ATTENTION SHOULD BEGIN WITHIN* 1 WK	1 MO	2-6 MOS	NAME OF CLINIC OR PHYSICIAN TO WHOM PATIENT WAS REFERRED AND DATE OF APPT.
1. History, Growth and Development					
2. Speech					
3. a) Vision					
b) Hearing					
4. Lab Tests Performed a) Anemia (Hb or Ht)					
b) Urinalysis					
c) Sickle Cell (as ind.)					
d) Lead Poisoning (as ind.)					
e) Tuberculin					
f) VDRL, GC (as ind.)					
Immunizations	GIVEN			ADDITIONAL DOSES (REQUIRED)	
DPT					
Polio					
Measles					
Rubella					
Mumps					

CONDITIONS	NORMAL	FURTHER MEDICAL ATTENTION SHOULD BEGIN WITHIN* 1 WK	1 MO	2-6 MOS	NAME OF CLINIC OR PHYSICIAN TO WHOM PATIENT WAS REFERRED AND DATE OF APPT.
6. Physical Examination a) Eye					
b) Ear					
c) Nose					
d) Mouth and Throat					
e) Dental-seen in past yr. Y N					
f) Head and Neck					
g) Cardio-Pulmonary (DP if over 11 years)					
h) Abdomen					
i) Genito-Urinary					
j) Muscule-Skeletal (include posture)					
k) Neurological					
l) Condition of Skin					
m) Behavior					
n) Other (specify)					

AFFIDAVIT: I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ITEMIZED HAVE BEEN FURNISHED. THE AMOUNTS LISTED ARE DUE AND, EXCEPT AS NOTED, NO PART THEREOF HAS BEEN PAID. PAYMENT OF FEES AND RATES MADE IN ACCORDANCE WITH ESTABLISHED SCHEDULES IS ACCEPTED AS PAYMENT IN FULL, AND THERE HAS BEEN COMPLIANCE WITH TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT OF 1964 WITHOUT DISCRIMINATION ON THE BASIS OF RACE, COLOR OR NATIONAL ORIGIN. I AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY OF SUCH ITEMIZED CARE, SERVICES AND SUPPLIES WHICH I HAVE PROVIDED AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED THEREFOR AS THE LOCAL SOCIAL SERVICES AGENCY OR THE STATE DEPARTMENT OF SOCIAL SERVICES MAY REQUEST. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT.

ADDITIONAL INFORMATION * REMARKS:

* If unable to arrange follow-up on urgent cases, please call Medical Director at local Department of Social Services.

DATE EXAMINATION COMPLETED: MO. / DAY / YR.

SIGNATURE

WHITE-BILLING COPY BLUE-CHAP OFFICE COPY YELLOW-SCHOOL HEALTH RECORD COPY PINK-PROVIDER COPY

Item 11: enter here the name of the primary recipient located on the left side of the Medicaid Identification Card.

Items 12 and 13: Enter here the complete address including apartment number of the primary recipient.

Items 14 through 16: Obtain from the child being examined or the parent the name/number of the school the child is attending and the borough (in New York City) in which the school is located as well as the grade in which the child is enrolled. This information is necessary to enable CHAP to coordinate efforts with the school health program and thereby avoid unnnecessary duplication of services. Note: Use N/A if the child is too young or is out of school.

Item 17: Enter here the age of the child being examined.

Items 18 and 19: These items remain blank.

Item 20 (line #101): Enter here the month, day and year of the CHAP appointment.

Item 21: Leave this item blank.

Item 22: This item is already entered.

Item 23: Leave blank. (The Medical Records Techician will enter "9034" here).

Item 24: This item is already completed.

Item 25: Leave this item blank. (The Medical Records Technician will enter $35.00

Item 26: Leave this item blank.

In the center of the CHAP W-294B Form the following two questions must be answered by the physician checking the appropriate box. The physician should check with the parent regarding the child's last periodic health examination.

1. Child is or will be in my continuing care ☐ Yes ☐ No

2. Is this the first Periodic Health Examination for this child during this year? ☐ Yes ☐ No

FINDINGS FROM HISTORY AND EXAMINATION: CHAP W-294B (continued)

The physician is completely responsible for entering the appropriate information on the bottom half of the W-294B Form. Each item performed must be checked off. This part of the CHAP form indicates normalcy or potential problems for which further medical evaluation is required, and if the child was referred for treatment, where and when further medical attention will be provided. This form is not to be submitted until all lab reports and test results are returned to the team and reviewed and noted by the physician. If any items are not performed or referral is not noted on positive findings, an explanation supporting this decision must be recorded on the patient's chart and on the W-294B Form under "Additional Remarks". A note should be attached to the form if more space is required.

Items 1 through 6 (Review of Conditions): Must be checked by the physician if normal. If abnormal, a note must be made on the form when appointment for treatment will take place for the condition and the place and date for appointments scheduled outside Roosevelt Hospital. In addition, one of the three options describing the time period between the examination and the scheduled appointment must be checked.

Lab tests: All lab tests performed must be noted in item 4 with results. If an additional lab test is performed, it should be noted with the results under "Additional Information-Remarks" at the bottom of the page. All positive tests results must be entered with reference to intended follow-up and date of scheduled appointment.

Note: the Roosevelt Hospital patient chart number must be entered in the "Additional Information-Remarks" area on the bottom of the form and the form signed and dated by the physician.

CBC, U/A, Tine are required lab tests. VDRL, Sickle Cell and Lead are to be performed as indicated.

Item 1 (History, Growth and Development: includes mental development. Items 3 through 4F must be performed according to the schedule of the New York City CHAP Guidelines. If any screening test is not up-to-date for the child's age, it is the responsibility of the physician to perform that test at the current visit.

Item 4a. (Hb or Hct): Borderline findings are to be reported as "needing further attention" at the discretion of the physician.

Item 4c. (Sickle Cell): When positive for sickle cell trait only, **write "Trait" or "Assumed Trait" in space for follow-up plans.**

Item 4d.(Lead): Count as positive only venous blood lead level of .04 or above.

Immunizations (lower left W294-B):

D.P.T. and Polio: check "given box" only if immunized at this current CHAP visit. If previously given record N/A. Check the "Immunization required" box when the series is incomplete. If adult DT serum is used, this should be noted next to the DPT box.

Measles, Rubella, Mumps: if the patient has had these immunizations or any of these diseases prior to the current CHAP examination, indicate N/A in "given box." Place a check in "additional doses required" when these immunizations are still pending. Note that if for any reason the immunizations scheduled could not be given at this visit, the patient must return at a future date before claims can be submitted for reimbursement.

Item 6a. (Eye): Refers to problems other than detected during vision screening.

Item 6b. (Ear): Refers to problems other than those detected during hearing screening.

Item 6g. (Cardio-pulmonary): The Citywide CHAP Guidelines (which follow this section) require that blood pressures be taken at age three and above.

Item 6h. (Other): Include here any problem or potential problem not identifiable by the tests and review of systems listed above on the form. Also include here any acute episodic conditions which may exist such as URI.

CONSULT THE FOLLOWING SUMMARY SHEET FOR INFORMATION ON IMMUNIZATIONS AND FOR ROUTINE CHAP PROCEDURES AND PERIODICITY SCHEDULE.

SUMMARY SHEET FOR ROUTINE EPSDT PROCEDURES AND VISIT SCHEDULE FOR INFANTS AND PRESCHOOLERS
AND OTHER CHILDREN

PROCEDURE \ AGE	*under 6 wks.	6 Wks.	3 Mos.	4-1/2 Mos.	6 Mos.	9 Mos.	12 Mos.	15 Mos.	18 Mos.	2 Yrs.	2-1/2 Yrs.	3 Yrs.	4 Yrs.	5 or 6 Yrs.	10,13,14 or 1[illegible] 17, 21 years
History	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Examination	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental Screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hemoglobin Electrophoreses							X								
Hematocrit					X		X			X				X	X
Micro-Lead							X			X					
Urinalysis												X	X	X	X
Vision Acuity Screening												X	X	X	X
Stereopsis Test												X	X	X	
Near Vision Test														X	X
Audiometric Screening												X	X	X	X
Immunization		DPT OPV	DPT OPV	DPT OPV		TINE	Measles-Rubella		DPT & OPV Boos-ters	TINE		TINE	TINE	TINE DPT & OPV Booster	TINE) Each Vis TD) - 14-15 yr

NOTE: For a first visit at any age a child should have all laboratory tests and screening procedures up to that age
*Newborn nursery visit.

IMMUNIZATIONS (LOWER LEFT OF THE W-294B): CHAP INSTRUCTIONS

The following responses are suggested as acceptable:

A. "Complete": If according to the physician's judgement, the patient has received all the appropriate immunizations for his age as outlined in CHAP Guidelines.

B. "Date Given": If according to the physician's judgement, the patient needed immunization(s) and was given at the time of this visit, the date must be indicated in the appropriate "given box."

C. "Number of additional dose(s) required": If according to the physician's judgement, additional dosage is required, the number of dose/doses should be entered in the appropriate box.

D. "Had Disease": This applies to children who have had the active disease (mumps, measles, rubella) and consequently require no passive immunization. Do not write N/A here (not applicable) as this entry will cause the form to be rejected.

E. "N/A (not applicable)": This will be considered acceptable as a response only in cases of girls 12 years and over who have not had the Rubella disease or previous immunization when the physician is reluctant to provide this immunization and children under age 1 year for mumps, measles, and rubella.

The CHAP Schedule of Immunizations is as follows:

At any age beyond six (6) years, basic immunizations should be completed if not already done so. The CHAP criteria for satisfactory basic immunization are:

Diptheria and Tetanus: 2 doses of adult DT toxoid, at least one month apart with a booster dose one year later.

Polio: two doses TOPV 6 to 8 weeks apart and a third dose 8 to 12 months later.

Measles: one dose of live, further attenuated measles vaccine or a history of measles.

Rubella: for children under 11 years of age and prepubertal. Selectively thereafter - one dose of rubella vaccine.

Mumps: one dose of live, attenuated mumps vaccine or a history of mumps.

In the 8th or 9th Grade or at age 13: a booster dose of adult DT vaccine for those children whose basic series was completed by age 6. For those children whose basic DT immunization was delayed, a DT booster should be provided 8 to 10 years after the primary series.

III. CHAP PROCEDURES AT ROOSEVELT HOSPITAL

CHAP Clinic Referral and Tracking Forms sent from the New York City CHAP office are received and logged at C&Y Administration. A continuing list of all referrals from CHAP is maintained there by Mrs. Klein. The Clinic Referral and Tracking Forms themselves are sent from C&Y Administration to the CHAP Medical Records Technician (E. Aldridge). She attempts to find Roosevelt Hospital chart or unit numbers for all CHAP referrals.

If the referred child is found to have a Roosevelt Hospital unit number (i.e., is known to Roosevelt), the Medical Records Technician will request that patient's chart from Medical Records and will review the chart. If this review indicates that the CHAP-referred child has been seen as a patient at Roosevelt Hospital for a comprehensive health examination in the past twelve (12) months, the Medical Records Technician will send a CHAP W-294A Form and the first copy of the Clinic Referral and Tracking Form to the New York City CHAP office.

If the CHAP referral, on the other hand, is discovered by the Medical Records Technician not to be known to Roosevelt Hospital, the Clinic Referral and Tracking Form is to be sent to the CHAP Appointments Secretary (O. Soloway). It is her responsibility to send CHAP appointment information letters to the families of these referred-children informing them of how to go about making

a CHAP Comprehensive Health Examination appointment at Roosevelt Hospital.

When a parent or member of the family of a CHAP-referral responds to this letter by calling for an appointment, or when the CHAP Appointments Secretary herself contacts those parents with telephones who have not responded to the letter within five working days, she will:

A) Give a verbal appointment to the parents for the child by utilizing the designated blocks of time scheduled for CHAP appointments;

B) Remind the patient's parents to bring the child's immunization record with them when they come for the appointment;

C) Obtain patient and family registration information over the phone;

D) Inform the teams in writing of all CHAP appointments made;

E) Send a yellow appointment card to the parents for each CHAP patient given an appointment. Both time and date of the appointment are to be noted on the appointment card;

F) Enter the CHAP appointment date on the Clinic Referral and Tracking Form and send copy #1 of this form to the New York City CHAP office;

G) Prepare a patient chart for the patient at least a day prior to the date of the CHAP scheduled appointment.

In the case of other children in the family whose names are not on the CHAP Clinic Referral and Tracking Form and who are not known to Roosevelt Hospital, these children should be referred to the appropriate teams by the registrar for comprehensive health examination appointments if the parents wish to schedule an appointment for them.

CHAP-referred patients who have either not responded or have not been contacted will be so noted on the Clinic Referral and Tracking Form. Copy #1 of this form will then be sent to the New York City CHAP office.

IV. CHAP SCHEDULE

TEAM A	MON. 9 AM	3 Pts.
	THURS. 9 AM	3 Pts.
	Thurs. 1 PM	3 Pts.
TEAM B	MON. 9 AM	3 Pts.
	TUES. 1 PM	4 Pts.
TEAM C	TUES. 9 AM	2 Pts.
	WED. 9 AM	2 Pts.
	THURS. 9 AM	2 Pts.
TEAM D	TUES. 9 AM	4 Pts.
	THURS. 9 AM	4-6 Pts.

TEAMS (LEADERS & NURSES) HAVE BEEN CONSULTED AND FEEL THEY CAN HANDLE THE LOAD

BEGINNING IN OCTOBER, TEAM D CAN HANDLE AN ADDITIONAL 4-6 PTS/WK ON THURS. AM

V. COMPREHENSIVE EXAMINATIONS FOR CHAP-REFERRED PATIENTS: SCREENING

A) If a CHAP-patient arrives at the team site ill, he or she is to be treated as a non-CHAP referred patient and a new appointment is to be scheduled for the CHAP examination by the team clerk-receptionist.

B) A CHAP W-294B form is to be filled out completely for each CHAP patient at each CHAP encounter (see CHAP periodicity) by the physician or other provider.

C) Laboratory forms to be used in connection with a CHAP visit are to be stamped by the team clerk-receptionist with the patient's plate and the team and CHAP are to be written on the forms as well in advance and placed in the patient's chart.

D) CHAP-referred patients are to be sent directly to their designated team upon arrival at the Registrar.

E) Screening is to include a physical examination by M.D. or Pediatric Nurse-Practitioner. Patient and family history is to be taken by the team nurse. A note must be made that there is no history of Pica or lead poisoning. If not, a lead screening test must be performed. Vision and hearing screening will be performed by the Senior Nursing Attendant and counselling by the Clinic Nurse, R.N.

F) A Medicaid voucher is to be completed if medication is required by the team clerk-receptionist.

G) Developmental Assessment must be determined for all age groups. A formal developmental test is mandated for all children under age 6. Any child not being referred to either Dr. Mullen (Chief Psychologist for C&Y) or the Developmental Assessment Project (age 3-8) must have a Denver Developmental test or other test done by the primary provider during the CHAP visit. Appointments to the Developmental Assessment Project located in the School of Nursing are made by calling extension 7143. Dr. Mullen will schedule her own appointments after receiving a green consultation sheet.

H) CHAP forms are to be retained in the special box in the teams until the results of laboratory tests and other procedures have been returned and entered. It is the team's responsibility to contact patients for TINE test results. All completed CHAP forms are to be sent to the Medical Records Technician in Room 306.

I) The Medical Records Technician (E. Aldridge) will receive a list containing the names of all CHAP-referred children screened on each "screening day." If a patient does not show for a CHAP Comprehensive Examination appointment, both the chart and all forms

are to be returned to her. She will then indicate on copy #2 of CHAP clinic and tracking form that the patient did not show and return the form to CHAP in New York City.

VI. FUTURE APPOINTMENTS FOR CHAP-REFERRALS

Future appointments are to be made as part of the Roosevelt Hospital CHAP Program for the following:

A) Dental screening. If not, some indication must be made on the W-294B Form that the patient is receiving dental care elsewhere. The date of the dental screening should also be indicated on the same form.

B) Specialty Clinics, when necessary. The date of appointment must be indicated on the CHAP W-294B. The green consultation sheets will be used for all referrals in Social Service, Nutrition, and Specialty Clinics.

C) Recall appointmentz to the teams (not in the CHAP Periodicity) are scheduled when deemed necessary by the physician. All three above appointment types are to be entered into the Meditech appointment system as regular visits.

D) The periodic examination visits (see attached Form W-293J for periodicity) which meet CHAP requirements can not be entered into the Meditech System. These periodic visits are to be continued as part of

the team's manual CHAP appointment schedule. The team clerk-receptionist assigns the appointment date and sends the information to the CHAP Appointments Sceretary (O. Soloway) who will maintain the master appointments list. A CHAP 294-B must be filled out completely at each of the periodic visits as well by the physician.

VII. PATIENT INFORMATION COLLECTION

A) Patients and their parents are to be sent to the Registrar to complete registration by supplying information not previously obtained by the CHAP Appointments Secretary (O. Soloway). A Xerox copy of the Medicaid Card and the Patient Plate will be made at this time at the Registrar's.

B) After a CHAP Comprehensive Examination is completed and the necessary patient information collected, the patient's chart and all forms are to be sent to the Registrar's (Mrs. A. Rosado) for entry into the patient data base. All contact forms, registration forms, and CHAP forms will be sent to the Medical Records Technician in Room 306.

C) When a CHAP referral is made by a provider to either a specialty clinic or team, the clerk-receptionist in the team will enter "CHAP REFERRAL" under the COMPLAINT AREA in the Meditech System when scheduling the appointment.

VIII. FOLLOW-UP

All the team members are responsible for follow-up care for all children entering the Project through CHAP. A second attempt at contact should be made for each CHAP "no-show." If this is unsuccessful, notify the CHAP office (Dora Hubert at 433-7410).

CITYWIDE GUIDELINES
EARLY AND PERIODIC SCREENING, DIAGNOSIS
AND TREATMENT PROGRAM (EPSDT)

I - PROGRAM FOR INFANTS AND PRESCHOOL CHILDREN*

Federal law mandates that all Medicaid programs provide certain health screening examination, diagnosis and treatment services periodically for children on Medicaid. All infants and children must receive periodic well child examinations which must include but not be limited to:

1. complete medical history
2. complete physical examination
3. assessment of physical growth
4. dental examinations
5. assessment of mental development
6. immunizations
7. hematology screening for anemia, and for lead poisoning and sickle cell disease when indicated
8. urinalysis
9. vision screening
10. auditory screening
11. summary diagnosis, and plan for the treatment and/or follow-up for significant abnormalities or referral and follow-up for these.

The following is a detailed description of the items which must be included.

1. COMPLETE MEDICAL HISTORY - This includes taking and recording the complete past medical history of the child: details of the pregnancy, birth and neonatal period; details of illnesses, accidents, health problems, previous health care and hospitalizations; a review of systems; a family health history; a social history. All or part of the complete medical history may be obtained from the parent on standard history forms. All of the complete medical history may be obtained and recorded by trained health assistants, provided it is reviewed by the physician. (See also #5, #6, #8. #9, #10.)

* Includes infants and children from birth to about 6 years of age. For children in school (approximately 7 years of age to 21) follow program on Page 7.

2. COMPLETE PHYSICAL EXAMINATION - The examination is to be performed by a licensed physician, or by a physician's associate or pediatric nurse practitioner under direct physician supervision. This is a physical examination of the unclothed infant or child and includes taking and recording the following measurements and vital signs:

   height, weight, head and chest circumference (on infants up to 1 year of age and selectively beyond that age), pulse rate, respiratory rate and blood pressure (age 3 and over). Temperature need only be taken on children who are acutely ill. (See also #3).

   A careful systematic examination of all parts of the body must be done, including a dental screening, otoscopic and funduscopic examinations. The goal should be a thorough search for the detection of abnormalities.

3. ASSESSMENT OF PHYSICAL GROWTH - This includes recording certain physical measurements (height, weight and head circumference) on a standard growth chart. This periodic recording enables the clinician to make a sound assessment of the child's physical growth. Standard growth charts must be used. Two are: (1) The Stuart Growth Chart, Department of Maternal and Child Health, Harvard School of Public Health, Boston, Mass. and (2) The Iowa Growth Chart, Iowa Child Welfare Research Station, State University of Iowa. The growth chart must be filed in the medical record of every infant and child who is given an EPSDT screening examination.

4. DENTAL SCREENING EXAMINATIONS - The following guidelines are presented not as a mechani to substitute for the definitive dental examination conducted by a dentist, but as the means for determining significant deviations from normal and the need to refer for dental examination and appropriate care. Screening dental examinations are to include: (a) soft tissue inspections - the condition of soft tissues should be assessed palpation for lymphadenopathy should accompany the general inspection of the tongue, lips, fauces and membranes for lesions, color, contour, texture and mobility. (b) oral hygiene-cleanliness of oral cavity and adequacy of tooth brushing technique should be assessed; existence of breath odors should be noted. (c) inspection of the teeth; abnormalities of morphology and eruption patterns should be noted; obvious gross or early decay, malalignment and discoloration also noted.

   Ideally, all children age 3 and over should be referred to a dentist for a complete dental examination, even when the above screening dental exam by the physician is normal.

5. ASSESSMENT OF MENTAL DEVELOPMENT - A detailed history of the development of the infant or child must be obtained. This history should include questions relating to motor, language and personal-social development. The administration of a standard (formal) preschool developmental screening test (such as the Denver Developmental Screening Test) is required. A summary developmental history must be recorded on the child's medical record.

6. IMMUNIZATIONS - This includes an assessment of routine immunizations given in the past and on updating of required immunizations in accordance with age. Routine immunizations should include immunizations against diphtheria, pertussis, tetanus, polio rubella, measles and mumps. A tuberculin skin test must also be done routinely on all tuberculin negative children. Any official immunization schedule may be used, such as that of the Academy of Pediatrics or the New York City Department of Health, Bureau of Child Health (see attached).

   Inquiries should be made about BCG vaccination if the child was born outside of the U.S. or if there is a known case of TB in the home. TB testing should precede or be concurrent with measles immunization.

7. HEMATOLOGY SCREENING - All infants and preschool children 6 months of age and over must have a hemoglobin or hematocrit test for anemia as part of the EPSDT examination. This test must be repeated routinely on all infants at 12 months of age and on all children at 2 years and 5 years of age and as indicated. A test for anemia should also be done on infants prior to six months who are "at risk" for anemia; e.g. prematures, twins. etc.

All infants and preschoolers one year of age and over who are "at risk" must have a test for sickle cell disease unless this has already been done and the results are known and recorded in the child's medical record. A screening test (such as the SICKLEDEX test) may be used but the more definitive hemoglobin electrophoresis is preferred. When a sickle cell screening test is used however and is positive, the definitive test for sickle cell disease (hemoglobin electrophoresis) must be done. Parents of all children with sickle cell trait or disease should be referred for sickle cell testing. They may be referred for this to a Department of Health Sickle Cell Clinic (telephone nearest District Health Center for information).

Parents of all infants and preschoolers must be routinely questioned about pica, possible exposure to peeling paint or plaster, and housing conditions. Children between 1 and 5 years of age in whom there is any possibility of lead ingestion, or who are found to be anemic, must have a lead screening test as part of the EPSDT examination (telephone nearest Dist. Health Center for information on the availability of lead tests).

8. URINE SCREENING - A history referrable to the urinary tract must be taken as part of the complete medical history. Special emphasis should be put on past urinary tract infections and/or signs or symptoms suggestive of urinary tract disease. Routine urinalysis must be done, including examination for protein, glucose, occult blood and Ph. A dip stick test may be used. A microscopic examination, determination of specific gravity and bacteriologic screening are also strongly recommended.

9. VISION SCREENING - Although formal vision testing is not required routinely before 3 years of age, the following procedures are to be utilized on all infants and pre-schoolers:

(1) The medical history should include history of any eye problem in the family as well as previous or present eye conditions/problems.

(2) Observation of the infant's/child's reaction to an object of interest such as light or a familiar toy can be used as indication of vision. This is checked separately for each eye.

(3) Motility screening tests should be done, including:
   (a) gross inspection of the eyes to determine the presence of any obvious strabismus.
   (b) observation of the position of the corneal reflection each eye when a light is used as a fixation target.
   (c) the "cover test" to determine any movement to assume fixation on a target held by the examiner when first one eye

is covered and then the other eye. This test is especially valuable in patients with a small amount of deviation not observed grossly. This small deviation can be noted in the movement of the deviated eye to fixate directly on the target when the opposite eye is covered.

At 3 years of age and over a screening visual acuity test for distance is to be performed. This is to be repeated yearly. The illiterate "E" Game (Snellen Test) or a series of pictures of familiar objects (umbrella, apple, house, in graded sizes) can be used.

For complete description of Snellen Test technique refer to "A Guide for Eye Inspection and Testing Visual Acuity of Preschool Age Children," available from the National Society for the Prevention of Blindness, Inc., 79 Madison Avenue, New York, N.Y. 10016.

At 3 years of age and over a test for stereopsis(fusion) must be done yearly. The Wurt Stereogram also called the "Fly Test", a commonly used test for stereopsis in young children, may be used. A complete description of this test and the required equipment is available from Titmus Optical Co., Inc., Petersburgh, Virginia 23803.

Occasionally there are 3-year-olds who cannot be conditioned sufficiently for reliable vision testing. When this occurs in a child who is "at risk" for a visual abnormality he must be referred for diagnostic work-up. Children determined not to be "at risk" (see below) may return in a few months for the vision test. In all cases where the vision test could not be done - regardless of reason - a dated note must be entered in the child's medical record stating reason why test was not done.

At age 5 years and over near vision is also to be tested as part of the EPSDT examination. One commonly used technique is the "Rosenbaum Pocket Vision Screener" available from:

SMP Division, Cooper Laboratory (PR) Inc.
P.O. Box 367
San German, Puerto Rico 00753

The same technique in covering the eyes is followed as for the distance Snellen Test with the exception that for the near vision test the card is held 12 - 14 inches from the child's face.

All non-physician personnel administering vision tests must be individually approved by the Department of Health.

The following criteria should be used for referral of infants and preschool children for complete opthalmologic evaluation. Children in one of more of the following categories are "at risk" for visual abnormality:

(1) All infants with a significant history and/or abnormal findings on physical examination of the eyes.
(2) All children who consistently present any of the signs of possible visual disturbances, regardless of visual acuity.
(3) All children with acuity test results (near or distance test) according to age as follows:

(a) 3-year-olds with visual acuity of 20/50 or less.
(b) 4, 5 and six-year-olds with visual acuity of 20/40 or less.
(c) children who show a one line or more difference between the 2 eyes even with passing standards; e.g., using the isolated E,

right eye tests 20/30, left eye 20/20.

(d) testing by the linear method (complete line) two line difference between each eye; e.g., right eye 20/40, left eye 20/20.

(4) All children who fail to indicate three dimensional vision for each of the three animals on the stereopsis test (Fly Test).

10. AUDIOMETRIC SCREENING - Although formal audiometric testing is not requirred routinely on infants and children under 3 years of age, the following points in the medical history are of great importance in all infants and children in order to delineate the possibly hard of hearing infant or child at the earliest possible time:

High risk group for hearing loss by history: prenatal history of toxemia, rubella, eclampsia, Rh incompatibility; perinatal history of marked prematurity, anoxia, jaundice, meningitis, encephalitis, sepsis, seizures; exposure of mother to ototoxic drugs (streptomycin, kanamycin, neomycin, quinine); family history of deafness; history of frequent ear infections or hearing loss.

Age-specific questions to be elicited for possible hearing problem are:

0 - 1 year old

Does he respond to sound from another room or when spoken to from out of sight?
Does he imitate his sound or other sound?
Does he wake up when you walk into the room?
Does he respond to outside sounds when in the carriage?
Does he always watch your face when you are speaking to him?
Does he stop crying when you talk to him?
Has he stopped babbling and not started talking to himself?
Does he respond to an unseen source of sound; e.g., wrist watch?

1 - 2 years old

Single words at one year old and 3-word phrases at 2 years old?
Do you think the child hears?
How does the child tell you what he wants? Gestures or speech?
Does the child talk with himself while playing? Does he use laughter?
Does he respond to the telephone ringing?

2 years old and older

Does he turn the television sound up?
Does his hearing fluctuate - particularly with colds?
Do you think he hears?
How does he tell you what he wants? Gestures or speech?

Physical examination including otoscopic, oral pharynx and nasal passages and a gross test for hearing are to be done on all infants and children as part of every routine physical exam. A description of findings, both positive and negative must be included in the clinicians write-up of the physical examination.

At age 3 years and above a yearly audiometric screening examination is to be done. The pure tone sweep test may be used for this purpose. It must be done at the 25 decibel (db) level and at the following frequencies: 1000, 2000, 4000, and 6000 Hertz. It must be individually administered by physicians or by personnel approved by the Department of Health. Children who fail the sweep test are to be given a pure tone threshold test following the sweep test. In addition, all children aged 3 and above who have a history of hearing difficulties, speech or language problems, learning disabilities or emotional difficulties must receive a pure tone threshold test.

For details of the threshold test see pg. 10 in guidelines for program for 7 to 21-year olds.

It is expected that a certain number of 3-year-olds cannot be conditioned with enough certainty to do a formal audiometric test. In such a situation, the child should be referred for complete audiologic work-up if by history and physical examination he is determined to be "at risk" for a hearing and/or speech problem (see below). Children determined not to be "at risk" may return in a few months for the test. In all cases where the audiometric test could not be done, regardless of reason, a note must be entered in the child's medical record by date, stating reason why test was not done.

Referral for complete evaluation must be made for:

1. all infants and children on whom a reasonable suspicion of hearing loss and/or speech problems exist following a history and physical examination as outlined above.

2. all children who fail to hear one or more of the test frequencies in either or both ears have failed the sweep test and must be given a threshold test.

3. all children aged 3 or over on whom the threshold test shows a hearing loss of 25 db or more (1969-ANSI) in the same ear for one or more frequencies.

11. SUMMARY DIAGNOSIS TREATMENT AND FOLLOW-UP - Children requiring diagnosis and treatment services must be given these at the time of the EPSDT examination if appropriate and there must be follow-up to ascertain results of treatment. Where the condition uncovered at time of the EPSDT examination requires more extensive diagnosis and/or treatment than is immediately available, referral for such services must be made in accordance with the attached standards (see III. Provider Standards, 2. Diagnosis and Treatment attached). The referring physician or clinic is responsible for follow-up. Whenever children are referred for any part of the EPSDT screening, such as a laboratory test, follow-up on the results is also the responsibility of the screening EPSDT provider (see III. Provider Standards, 1. Basic Elements for a Screening EPSDT Provider attached). A summary diagnosis and plan for treatment or referral must be recorded on each child's medical record.

12. PERIODICITY - of the EPSDT examination should conform to any official schedule for well baby/child care visits, such as that of the American Academy of Pediatrics or the New York City Department of Health, Bureau of Child Health (see attached).

13. QUALITY CONTROL - The New York City Department of Health in addition to setting standards for the EPSDT Program will also assess the quality of servides delivered by providers participating in this program by periodic audit of provider medical records.

PROGRAM FOR AGES 7 TO 21

PERIODICITY

For children between the ages of 7 and 17, the vast majority of whom are attending school, periodicity can most easily be related to shool grades; there should however be some flexibility in unusual situations, to avoid repeated screening tests at unnecessarily close intervals.

Generally, Medicaid EPSDT should be carried out at the following times:

At admission to school (Ktg. or 1st grade)
In the fourth grade of school (or at age 10)
In the eighth or ninth grade, whichever immediately precedes high school (or at age 13)
In the twelfth grade (or at age 17)
At age 21

CONTENT

Each examination should include the following elements, with certain exceptions and modifications as noted under STANDARDS:

1. Complete medical history
2. Complete physical examination
3. Assessment of growth and development.
4. Dental screening.
5. Vision screening.
6. Hearing screening.
7. Anemia screening.
8. Urine screening.
9. Blood Pressure.
10. Tuberculin test.
11. Immunizations.
12. Serologic test for syphilis.
13. Counselling, referral, and follow-up to ensure treatment of health problems found.
14. **Rubella titer for adolescent women.**

1. MEDICAL HISTORY: For a new patient, a complete family history, past medical history, and review of systems must be obtained and recorded. This must include details of pregnancy, birth and neonatal period, development, illnesses, accidents, hospitalizations, disabilities, health habits, review of systems, and immunizations. For patients on whom the examining agency already has a complete medical record, history may be confined to the interval since last seen and a review of systems. For the 4th grade examination, efforts should be made to have the parent and to obtain the history by direct questioning. For the eighth and twelfth grades, history may be obtained by having the parent complete a written questionnaire or check list; this is to be supplemented by direct questioning of the child. At age 21, history may be obtained directly from the patient. At any age, history may be obtained initially by trained health assistants, provided the physician reviews and supplements it at the time of examination.

2. PHYSICAL EXAMINATION: To be performed by a licensed physician, physician's assistant, or nurse practitioner. Child to be undressed except for underpants. Exam to include: posture; gait; coordination; speech; skin; muscle development and tone; screening orthopedic exam, including observation of the bent back; eye movements; Hirschberg test or cover test for strabismus; lids, conjunctivae, cornea and sclera; pupils and pupillary reflexes; inspection of nose, teeth, mouth and throat; otoscopic examination; neck; thyroid; lymph glands; auscultation of heart in erect and recumbent positions; lungs; palpation of abdomen in recumbent position; palpation of breasts; femoral pulse; use of extremities and digits; knee jerks; femoral or inguinal hernia; Inspection of genitalia and, in males, palpation if necessary for undescended testicles.

   Ideally, blood pressure is taken by the same examiner as part of the physical examination.

   Funduscopic examination is also recommended as a part of the complete physical examination.

3. ASSESSMENT OF GROWTH AND DEVELOPMENT: Height and weight are to be measured and recorded at each examination and compared with previous measurements and familial habitus. School and job performance are to be inquired into. Sexual maturation as determined from both history and physical examination is to be noted. Onset of menarche and date of last menstrual period should be recorded.

4. DENTAL SCREENING: Dental screening may be done by the physician as part of the general physical examination, provided there is referral of all patients for definitive dental diagnosis and treatment. To all intents and purposes, all children suffer from dental caries and an appreciable number suffer inflammatory diseases of the supporting structures of the teeth. In addition, significant numbers are handicapped by extensive tooth losses and by severe malocclusions. As a consequence, children are advised to receive dental examination and definitive treatment annually.

   For these purposes then, the oral inspections by physicians should be directed to establishing urgency and priority of referral for dental examination and treatment.

   Following are the criteria to be used in establishing urgency of referral:

   a. Refer immediately:

      cases with evidence of having recently experienced acute pain or infection
      cases with evidence of rampant or extensive caries
      cases with hypertrophied, exudative gingivitis
      cases with suspicious oral lesions, lymphadenopathy or other conditions suspected as life endangering.

b. Refer as early as practicable:

cases with extensive tooth loss or with severe malocclusions
cases with large numbers of fillings who have not visited a dentist within a year
cases with poor oral hygiene or large calcareous deposits
cases with loose or displaced teeth

c. Suggest dental attention within the year to all others.

5. VISION SCREENING: Vision screening, like dental screening, should be done annually throughout the school years. It should include the following elements:

1. Snellen Distant Visual Acuity Test. Procedures for testing and referral criteria are contained in "A Guide for Eye Inspection and Testing Visual Acuity of School Age Children," published by the National Society for the Prevention of Blindness, Inc., New York, New York.

2. Snellen Near Visual Acuity Test.

3. Stereopsis (fusion) using the Wurt Stereogram ("Fly Test").

All non-physician personnel carrying out and/or supervising the above procedures must have had training and experience deemed adequate by the Department of Health.

Following are the criteria for referral of school children for complete ophthalmologica examination:

1. All children who consistently present any of the signs of possible visual disturbances, regardless of visual acuity.
2. Children of 7 and 8 years of age with visual acuity of 20/40 or less (near or distance test).
3. Children 9 years of age and above with visual acuity of 20/30 or less (near or distance test).
4. Children who show a one line or more difference between the two eyes, even within passing standards.
5. Children who fail to indicate 3 dimensional vision for each dot (in circle) in each of the first 6 (numbered) areas on the fusion test.

6. HEARING SCREENING: All school-age children must have a hearing screening test as part of the first EPSDT exam and thereafter at ages 6,7,11,13, and 15 years, and children in special education classes.

A hearing test should never be administered while a hearing aid is being worn by a child.

Screening should consist of a pure tone sweep test, individually administered at the 25 decibel (db) level at frequencies of 1,000; 2,000; 4,000; and 6,000; Hz (frequencies

If a child fails to hear one or more of the test frequencies at 25 db in either or both ears, he has failed the screening test and should be given a threshold test. In addition, all children who have a history of hearing difficulties, speech or language problems, learning disabilities or emotional difficulties must receive a threshold test.

ADMINISTERING THE THRESHOLD TEST (Pure tone)

It is advisable to test the child's right ear first, beginning at the test frequency 1000 Hz. After the child's threshold for this frequency is determined, proceed to obtain his hearing threshold for the remaining progressively higher test frequencies (2000, 4000, and 6000 Hz.) When this is completed, retest the child's hearing acuity in the right ear at the test frequency 1000 Hz. Follow the same test procedure to obtain the hearing thresholds for the child's left ear. The threshold for each of the various test frequencies is determined as follows:

1. Present the test tones at the 50 decibel level (1969-ANSI). If the tones are not heard at this level, increase the intensity in 10 - decibel steps until the child responds to the sound. (Keep the tone control switch in the "off" position in order to decrease the possibility of extraneous dial clicks being heard by the child.)

2. Decrease the intensity of the tone in 10 - decibel steps until the child indicates that the tone is not heard.

3. Increase the intensity of tone in 5 - decibel steps until the child indicates that the tone is heard again.

4. Repeat this threshold-seeking maneuver until you obtain identical response at least 50 percent of the time. The response received will be the child's threshold of hearing.

5. Record the threshold values for each test frequency on a Worksheet. If consistent response cannot be obtained for a given frequency, obtain the thresholds and complete the audiogram for the other frequencies, then return to the frequency that gave the difficulty. If the acuity of the ear first tested shows a significant loss, retest this ear after the test has been completed on the other ear. When administering this test, avoid presenting the tones in rhythmic sequences and take into consideration the reaction time of the child being tested.

6. Turn off the audiometer when not in use.

7. In between tests, clean the earphones with cotton balls moistened with Zephiran Chloride, Aqueous Solution 1:750.

All non-physician personnel carrying out and/or supervising the above procedures must have had training and experience deemed adequate by the Department of Health. The audiological equipment and testing facilities must meet acceptable standards. The Department of Health and its Advisory Committees are available for specific recommendations.

Referral: refer for complete work-up if a threshold test shows a hearing loss of 25 decibels or more (1969-ANSI) in the same ear for one or more frequencies. (See III. Provider Standards, 2. Diagnosis and Treatment.
An audiometric test should never be administered while a hearing aid is being worn by a child.

7. ANEMIA SCREENING: Hemoglobin or hematocrit should be done on all patients, and sickle-cell screening where indicated, by laboratory personnel licensed by the New York City Department of Health. A hemoglobin electrophoresis is highly recommended as the best test for sickle-cell screening and it need not be repeated.

8. URINE SCREENING: A dipstick test for occult blood, protein, glucose and Ph is acceptable for urine screening. Microscopic examination should be included wherever feasible. If "clean" urines can be obtained and cultured, this constitutes the best screening test for urinary tract infection.

9. BLOOD PRESSURE: Preferably, this is taken by the physician at the time of the complete examination. Alternatively, it may be done by a nurse or paraprofessional, if the training and supervision of such personnel is acceptable to the Department.

10. TUBERCULIN TEST: This is to be applied by a physician, nurse or adequately trained paraprofessional. Reading is ideally done by the same personnel; however, if a return visit for reading is not feasible, instructions to the parent or to older children, with a postcard return report, may be used.

11. IMMUNIZATIONS: The schedule of immunizations is as follows:

At any age beyond 6 years, basic immunizations should be completed if not already given. Criteria for satisfactory basic immunization are:

Diptheria & Tetanus: Two doses of adult DT toxoid, at least one month apart, with a booster dose one year later.

Polio: Two doses TOPV 6 to 8 weeks apart, with a third dose 8 to 12 months later.

Measles: One dose of live, further attenuated measles vaccine; or a history of measles.

Rubella: For children under 11 years and prepubertal; selectively thereafter: One dose of rubella vaccine.

Mumps: One dose of live, attenuated mumps vaccine; or a history of mumps.

In the 8th or 9th Grade or at age 13: A booster dose of adult DT vaccine, for children whose basic series was completed by age 6. For children whose basic DT immunization was delayed, a DT booster should be provided 8 to 10 years after the primary series.

12. VENERAL DISEASE SCREENING: Serologic test to syphilis should be offered to all patients at age 13 and over, and particularly urged for those who are sexually active. Gonococcal smears should be done selectively. It is to be noted that parental consent is not required for these tests as it is for all other elements of the examination. If the tests are refused, specific note is to be made of this fact in the record, and both at the original visit and subsequent visits further attempts should be made to obtain acceptance, if the youngster is sexually active. The serology test is to be performed by laboratory personnel licensed by the New York City Department of Health.

13. COUNSELLING, REFERRAL, AND FOLLOW-UP: Youngsters requiring diagnostic and treatment services must be given these at the time of the EPSDT examination, if possible and appropriate, and there must be follow-up to ascertain the results of treatment. Where the condition uncovered at the time of the EPSDT examination requires more extensive diagnosis and/or treatment than is available by the examiner referral for such services must be made. (See III Provider Standards, 2. Diagnosis and Treatment, attached.) The referring physician or clinic is responsible for follow-up. Whenever youngsters are referred for any part of the EPSDT Screening, such as a laboratory test, follow-up on the results is the responsibility of the referring physician or clinic.

A summary of the screening findings and a plan for treatment or referral and follow-up must be recorded on each youngster's medical record.

III PROVIDER STANDARDS

All providers, both individual practitioners and groups/clinics, must meet the following standards in order to participate in the EPSDT Program.

1. BASIC ELEMENTS FOR A SCREENING EPSDT PROVIDER

(a) Any Medicaid-certified physician may be a screening provider. Those aspects of screening which may be performed by non-physicians as specified by the Department of Health must be under the direct supervision of a Medicaid-certified physician.

(b) The screening provider must have an organization capable of and responsible for record keeping, follow-up and referral in addition to the other basic elements specified in parts 1 and 2 of these standards and guidelines.

(c) All screening EPSDT tests and procedures (except the lead test) must be done by the basic screening provider. However, there might be exceptions regarding one - but only one - of the other screening elements. In such cases where the screening provider does not provide all tests and procedures (except the lead test) the Department of Health will specifically review and approve such alternative arrangements as might be proposed by the provider.

(d) Specific formal agreement is required between the screening provider and an appropriate back-up hospital. Copies of this agreement must be made available by the screening provider to the Department of Health for audit upon request. The back-up hospital should have an approved residency training program in pediatrics. The Department of Health, under special circumstances, may waive the latter requirement.

(e) The elements of any back-up agreement must be approved by the Department of Health, similar to the latter's role in standard-setting.

2. DIAGNOSIS AND TREATMENT

(a) Conditions where approved centers only of NYC Health Department Bureau for Handicapped Children must be used for both definitive

diagnosis and treatment:

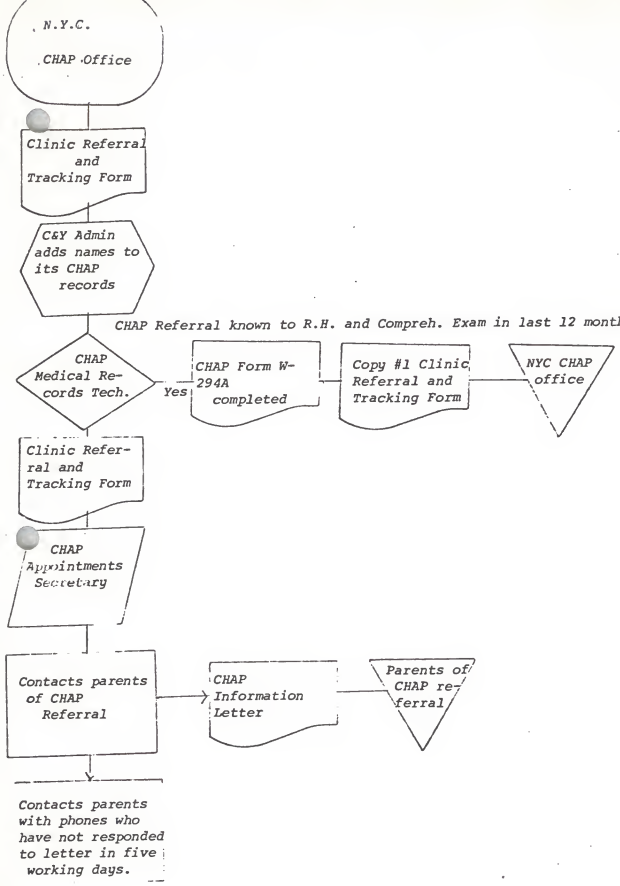
Amputee
Cardiac requiring definitive diagnostic procedures or surgery
Cystic Fibrosis
PKU
Major Congenital G.I. Anomalies
Meningo Myelocele
Hydrocephalus (unless arrested)
Leukemia and other malignancies
Cleft Palate
Blood dyscrasias with coagulation defect
Impaired Hearing

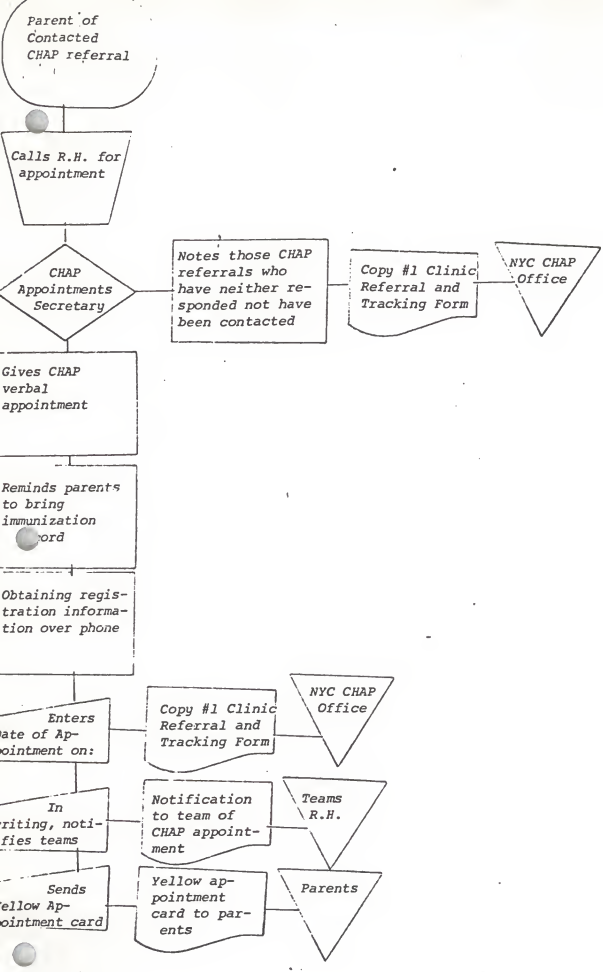
(b) Conditions where only specified approved centers (of Bureau for Handicapped Children) or Board-eligible or certified specialists pertinent to that specialty diagnosis, should be used for definitive diagnosis. Treatment elsewhere may be provided as approved by the Department of Health. Included are all conditions under Bureau for Handicapped Children not listed under (a), above e.g., chronic asthma, convulsive disorders, orthopedic conditions, etc. (A list of the New York City Department of Health Bureau for Handicapped Children Approved Centers may be obtained by written request to the above Bureau at 350 Broadway, New York, New York 10013, 5th Floor.)

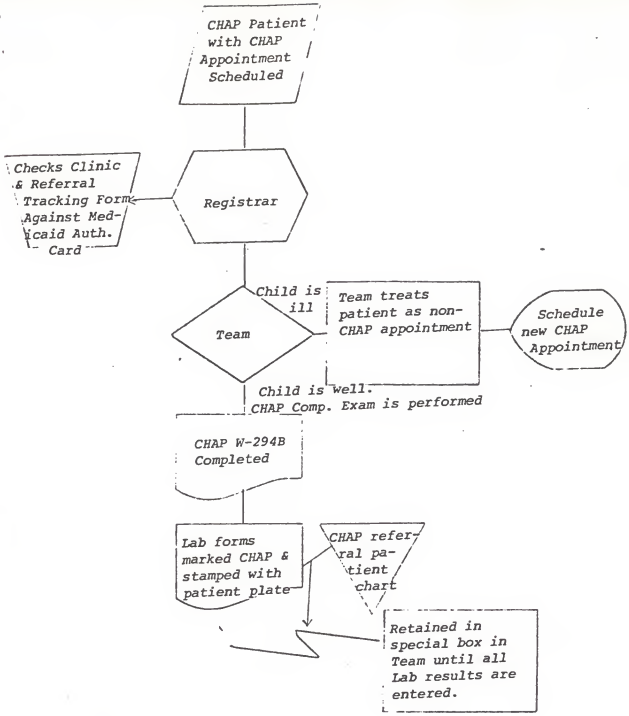
(c) Those conditions where treatment may be given only in an approved (Bureau for Handicapped Children) center:

Chronic renal dialysis and transplant

Children who do not have potential physical handicaps but require referral for diagnosis and/or treatment of potential developmental and/or emotional problems must be referred to hospitals with approved pediatric residency programs or to the appropriate board eligible/certified specialist.


N.Y.C.
CHAP Office
Clinic Referral and Tracking Form
C&Y Admin adds names to its CHAP records
CHAP Referral known to R.H. and Compreh. Exam in last 12 months
CHAP Medical Records Tech.
Yes
CHAP Form W-294A completed
Copy #1 Clinic Referral and Tracking Form
NYC CHAP office
Clinic Referral and Tracking Form
CHAP Appointments Secretary
Contacts parents of CHAP Referral
CHAP Information Letter
Parents of CHAP referral
Contacts parents with phones who have not responded to letter in five working days.


Parent of Contacted CHAP referral
Calls R.H. for appointment
CHAP Appointments Secretary
Notes those CHAP referrals who have neither responded not have been contacted
Copy #1 Clinic Referral and Tracking Form
NYC CHAP Office
Gives CHAP verbal appointment
Reminds parents to bring immunization ord
Obtaining registration information over phone
Enters ate of Appointment on:
Copy #1 Clinic Referral and Tracking Form
NYC CHAP Office
In riting, notifies teams
Notification to team of CHAP appointment
Teams R.H.
Sends ellow Appointment card
Yellow appointment card to parents
Parents


CHAP Patient with CHAP Appointment Scheduled
Registrar
Checks Clinic & Referral Tracking Form Against Medicaid Auth. Card
Team
Child is ill
Team treats patient as non-CHAP appointment
Schedule new CHAP Appointment
Child is well. CHAP Comp. Exam is performed
CHAP W-294B Completed
Lab forms marked CHAP & stamped with patient plate
CHAP referral patient chart
Retained in special box in Team until all Lab results are entered.

APPENDIX C

BCHS REPORTING

1: Documentation
2: Programs

ROOSEVELT HOSPITAL PEDIATRIC HEALTH MANAGEMENT SYSTEM

DOCUMENTATION FOR BCHS REPORTING

The requirements for C&Y reporting are as follows:

A. Prepare a one-time only tape of C&Y active registrants up through December 31.

B. Each month prepare a listing of new C&Y registrants for that month.

C. Each month prepare a listing of encounters for that month.

The layouts for Item A and Item B are the same. Following them are general requirements, tape layouts, and source for new C&Y reporting.

General Requirements

1. We report events on Y (Col. 1, Card 1, Form: Patient Registration) only.

2. Tapes will be 1600 BPI, 9 track.

3. Tapes will have no headers, be unlabeled, and unblocked.

4. All alpha data will be left justified and end with blanks.

5. All numberic data will be right justified with lead zeros.

6. Edit Requirements: State requires that we track both alphs and numeric fields for proper length (values seem unimportant to them).

The following attachments are file descriptions including source from present Roosevelt Hospital systems to facilitate programming efforts.

ITEMS A&B, C&Y PATIENT REGISTRATION

File Description

Data reported for (Y) Patients only (Card 1, Col. 1)

Record Position	Description	Field Length	Roosevelt Data Source
1-6	Project ID	6N	Always use 000018
7-12	Registration Date	6N	Card 1 Col. 35-40
13-30	Name Last	18A	Card 1 Col. 8-34 (Truncate if necessary stop at first blank)
31	First Initial	1A	Cards Col. 8-34 (first alpha punch after 1st blank)
32	Middle Initial	1A	Cards Col. 8-34 (first alpha punch after 2nd blank if available)
33-43	Patient ID	11N	Card 1 Col. 2-7 (use lead zeros)
44	Race	1N	Card 1, Col. 48; Translate:
45	Sex	1N	Card 1, Col. 47
46-51	Date of Birth	6N	Card 1, Col. 41-46
52-53	Net Income	2N	Card 2, Col. 40; Translate:
54-55	No. in family	2N	New Field Card 7, Col. 71-72, Card 2, Col.43
56	Expected Source of payment	1N	Registration Form Card 2, Translate:
57	-		
58-62	Zip Code	5N	Card 1, Col. 69-73
63-64	County	2N	New Field, Card 7, Col. 76-77
79	Form Status		Always a 1 which designates new registration

Card 1, Col. 48; Translate:

RH	State
1	1
2	2
315	5
4	7

Card 2, Col. 40; Translate:

RH	State
1	0
2	1
3	2
.	.
.	.
.	.
9	8
0	9

New Field Card 7, Col. 71-72, Card 2, Col.43

RH	State
1,2	01
3	03
4	06

Registration Form Card 2, Translate:

RH	State
1,2	1
3	3
4	6

ITEM C: C&Y ENCOUNTER

File Description

Data reported for (Y) Patients only (Cards, Col. 1); for Medical Encounters Contact Form III (Cards 3 and 8)

Record Position	Description	Field Length	Roosevelt Data Source
1-6	Project ID	6N	Always use 000018
7-10	Staff ID	4N	Card 3, Col. 14-16 (use lead zero)
11-16	Date	6N	Card 3, Col. 8-13
17-27	Patient ID	11N	Card 3, Col. 2-7 (use lead zeros)
28	Place of Encounter	1N	Card 3, Col. 17; Translate:
			RH / State: 1,2,3,4,5,6,8,9 / 3; 7 / 5
29-30	Type of Encounter	2N	Card 3, Col. 78-79; if punched 01, use, otherwise leave blank

For Dental Encounters: Contact Form IV (Card 5)

1-6	Project ID	6N	Always use 020811
7-10	Staff ID	4N	Card 5, Col. 14-16 (use lead zeros)
11-16	Date	6N	Card 5, Col. 8-13
17-27	Patient ID	11N	Card 5, Col. 2-7 (use lead zeros)
28	Place of Encounter	1N	Card 5, Col. 17; Translate:
			RH / State: 1,2,3,4,6,8,9 / 3; 5 / 4; 7 / 5

For Other Encounter: Card 4

1-6	Project ID	6N	Always use 020811
7-10	Staff ID	4N	Card 4, Col. 14-16 (use lead zeros)
11-16	Date	6N	Card 4, Col. 8-13
17-27	Patient ID	11N	Card 4, Col. 2-7 (use lead zeros)
28	Place of Encounter	1N	Card 4, Col. 19; Translate:
			RH / State: 1,3,8,9,0 / 3; 2,4 / 6; 5 / G; 6 / 7; 7 / 5
29-30			Card 4, Col. 33-34. If punched 01 translate to 02, otherwise leave blank

APPENDIX D

LETTER FROM MHRA TO TITLE V BCRR REPRESENTATIVES

MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW YORK CITY, INC.
40 Worth Street – New York, New York 10013
Telephone (212) 285-0220

Dr. RAYMOND FINK, President
LUCIL[illegible]EINBLUTH, Executive Director

OFFICE OF THE EXECUTIVE DIRECTOR

TO: TITLE V BCRR Representatives

FROM: Henry J. Policare

RE: Problems and Revisions

DATE: 3/7/77

Dr. Uppal has informed me that the BCRR forms as they are now being prepared present a potential danger to the accuracy of the data we will be able to obtain from them. Much of the writing on these forms is illegible or very nearly illegible. The potential for errors in keypunching such data is great. Also, dots, dashes, slashes and other marks are being placed in, around, and between numbers. All I.D. numbers are to be numeric characters only. They should not include dots and dashes, nor should dates include slashes. If you cannot code an item or you need a new, special code -- it is not appropriate to write an abbreviation or letters or some other number in that box. If you have problems in coding please call me and I will be glad to help you. Finally the appropriate routing of problems and questions is through my office, not direct to Dr. Uppal. In the future, we will require that this procedure be adhered to.

We have just received new encounter and registration forms. It is our hope that these new forms will help to ease some of the problems currently encountered in completing them. Please call my office and make arrangements for obtaining a supply of these forms.

One additional code has been added that does not appear on these forms. On the registration form in the "New, Update, Term." column a code 4 will represent a patient who is being "reinstated" in your program. "Reinstated" means that the patient was previously entered as "New", then "Terminated" and is now becoming active again.

APPENDIX E

INFORMATION REQUIREMENTS FOR REGISTRATION, INITIAL HEALTH HISTORY, & ENCOUNTER

ROOSEVELT HOSPITAL PEDIATRIC HEALTH MANAGEMENT SYSTEM

INFORMATION REQUIREMENTS FOR REGISTRATION

Unit Number

Registration Date

Name of Patient

Address of Patient

Census Tract

Patient's Home Phone

Patient Ever Been Seen at Hospital?

Provider Assignment

Referral Source (list)

Date of Birth

Place of Birth

Race

Primary Language Spoken in Home

Name of Natural Mother

Maiden Name of Mother

Birth Date of Mother

Race of Mother

Marital Status of Mother

Birthplace of Mother

Name of Natural Father

Age of Father

Birthplace of Father

Father's Marital Status

Father's Race

Can Parents Read?
- No
- English
- Spanish
- English and Spanish

Name of Legal Guardian

Name of Head of Household

Household Head's Relationship to Patient (describe)

Sex of Household Head

Number in Household
- Children
- Adults

Financial Code

Medicaid Case Name/Third Party Insurer

Medicaid Number/Third Party Insurer's Number

Welfare Center Code

Name of Person Financially Responsible

Address of Person Financially Responsible

Telephone Number of Person Financially Responsible

ROOSEVELT HOSPITAL PEDIATRIC HEALTH MANAGEMENT SYSTEM

INFORMATION REQUIREMENTS FOR HEALTH HISTORY

Date

Patient's Name

Patient's Birth Date

Patient's Birth History
- How many Children has Mother Had?
- Patient's Birth Order
- Has Mother had any:
  - Abortions
  - Miscarriages
  - Premature Births
  - Cesarean Births
- Name and Location of Patient's Delivery Site
- Mother's Health During Patient's Pregnancy
- Was Delivery Normal?
- Multiple Birth
- Did Patient Arrive
  - On Time
  - Premature
  - Late
- Patient's Birth Weight

Family Health History (list)
- Mother's Illnesses
- Father's Illnesses
- Mother's Side
- Father's Side
- Sister's
- Brother's

Patient's Health History; Has Child Ever Had
- Whooping Cough
- Measles (Rubeola)
- Rubella (German Measles)
- Mumps
- Chicken Pox
- Asthma
- Rheumatic Fever
- Blood Disorders (Anemia)
- Seizures
- Other

Does Child Have Any Allergies?

List Hospitalizations, Starting with Most Recent
- Reason
- Number of Days
- When?
- Where?

Does Child have Any Chronic or Handicapping Conditions?
- Describe

Does Child Have Any Difficulties With Eating?
- Describe

Does Child Have Any Social Problems?
- Describe

At What Age Did Child
- Follow Movement
- Laugh
- Hold Head Erect
- Roll Over
- Sit
- Crawl
- Stand Up Alone
- Wave Goodbye
- Walk Alone
- Climb Alone
- Use Cup and Spoon
- Speak Words
- Walk Up and Downstairs
- Use Full Sentences
- Control Bladder and Bowel

What School Does Patient Attend?
- Grade
- Location

Immunization Profile
- DPT
- Polio
- Measles (Rubeola)
- Rubella (German Measles
- Mumps
- Td
- Other

Provider Signature

ROOSEVELT HOSPITAL PEDIATRIC HEALTH MANAGEMENT SYSTEM

INFORMATION REQUIREMENTS FOR MEDICAL ENCOUNTERS

Unit Number

Name of Patient

Address of Patient

Telephone Number

Date of Encounter

Encounter Provider

Type of Encounter:
- Ill child/acure episodic/scheduled
- Ill child/acute episodic/walk-in
- Ill child/acute follow-up/scheduled
- Ill child/acute follow-up/walk-in
- Assessment
- Prevention/scheduled
- Prevention/walk-in
- Chronic health maintenance/scheduled
- Chronic health maintenance/walk-in

Patient's Major Complaints (3)

Health History Update
- Any Trips Outisde Continental U.S.A. Since Last Encounter (2)
- Date
- Length of Stay

- Recent Hospitalizations
  - Any Recent Hospitalizations Since Last Encounter?
  - How Many Hospitalizations?
  - What was the Reason for Each?
  - Where was Patient Hospitalized?
  - How Many Days Hospitalized?
  - When Hospitalized?

- Recent Illnesses/Injuries
  - Any Illnesses/Injuries for Which Patient was not Hospitalized since Last Encounter (all)
  - Contagious?
  - Date

Health History Update (continued)

- Current Medications (for each)
  - Name
  - Prescription
  - Prescribing Physician Name and Location
  - Daily Amount
  - Length of Time Taken
- Any Drug Sensitivities
- Immunization Review
  - Immunizations Since Last Encounter (list)
  - Any Verifications Available?
- Any Close Relative Been Ill or Died Since Last Encounter?
  - If so, indicate relationship and illness

Encounter Data

- Height
- Weight
- Head Circumference
- Temperature
- Pulse
- Blood Pressure
- HBG
- HCT
- WBC x 100
- Urine Analysis
- Lead
- Tine
- Sickle Cell
- V.D.
- Other
- X-Rays
  - Skeletal
  - Chest
  - Abdomen
  - Other
- Physical Systems Examination
  - Mouth
  - Teeth
  - Eyes
  - Head & Neck
  - Nodes
  - ENT
  - Cardio-Pulmonary

Physical Systems Examination (continued)
- Abdomen
- Neurological
- Genito-Urinary
- Musculo-Skeletal
- Skin
- Speech
- Vision
- Hearing
- Other

Has Visited Dentist in Last Year
Summary of Abnormal Findings

General Review
Changes in:
- Social Behavior
- Nutrition
- School Behavior
- Other

Developmental Milestones
- Follows Movement
- Laughs
- Holds Head Erect
- Rolls Over
- Sits
- Crawls
- Pulls up to Standing
- Waves Goodbye
- Walks Alone
- Climbs
- Uses Cup and Spoon
- Speaks Words
- Walks Up and Downstairs
- Uses Full Sentences
- Controls Bladder and Bowel

Diagnosis (list all)
Severity
- Non-significant
- Acute
- Chronic

Status
- Provisional
- Established

Type
- New
- Existing Condition

Procedures (list all)
- Procedure
- Type
  - Diagnosis Relevant
  - Routinely Undertaken

Medications (list all)
- Name
- Applied
- Number of times per day
- Number of days

Treatment Plan (describe)

Other Health Maintenance Site (describe)

Immunizations Administered
- DPT
- Polio
- Measles (Rubeola)
- German Measles (Rubells)
- Mumps
- Td
- Other

Immunizations Scheduled
- Type
- Date Scheduled

Does This Encounter Constitute a Complete Health Assessment?
- Initial
- Periodic

Disposition of Patient
- Referral
- Recall for This Diagnosis
- Contact Provider for Appointment if Problem Persists
- Schedule Next Assessment

Provider Signature

FINANCIAL STATUS REPORT

(Follow instructions on the back)

1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED: DHEW-SRS-OPRE

2. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER: 11-P-90245/2-01

OMB Approved No. 80-R0180

PAGE 1 OF 1 PAGES

3. RECIPIENT ORGANIZATION *(Name and complete address, including ZIP code)*
NYS Department of Social Services
40 North Pearl Street
Albany, NY 12243

4. EMPLOYER IDENTIFICATION NUMBER: 14-6013200

5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER: 73-7785

6. FINAL REPORT: ☒ YES ☐ NO

7. BASIS: ☒ CASH ☐ ACCRUAL

8. PROJECT/GRANT PERIOD *(See instructions)*
FROM *(Month, day, year)*: 9/5/75
TO *(Month, day, year)*: 3/15/77

9. PERIOD COVERED BY THIS REPORT
FROM *(Month, day, year)*: 1/1/77
TO *(Month, day, year)*: 3/15/77

10. STATUS OF FUNDS

PROGRAMS/FUNCTIONS/ACTIVITIES ▶	(a)	(b)	(c)	(d)	(e)	(f)	TOTAL (g)
a. Net outlays previously reported	$	$	$	$	$	$	$ 146,612
b. Total outlays this report period							17,201
c. *Less:* Program income credits							-0-
d. Net outlays this report period *(Line b minus line c)*							17,201
e. Net outlays to date *(Line a plus line d)*							163,813
f. *Less:* Non-Federal share of outlays							-0-
g. Total Federal share of outlays *(Line e minus line f)*							163,813
h. Total unliquidated obligations							-0-
i. *Less:* Non-Federal share of unliquidated obligations shown on line h							-0-
j. Federal share of unliquidated obligations							-0-
k. Total Federal share of outlays and unliquidated obligations							163,813
l. Total cumulative amount of Federal funds authorized							164,253
m. Unobligated balance of Federal funds							440

11. INDIRECT EXPENSE

a. TYPE OF RATE *(Place "X" in appropriate box)* ☐ PROVISIONAL ☐ PREDETERMINED ☐ FINAL ☐ FIXED

b. RATE	c. BASE	d. TOTAL AMOUNT	e. FEDERAL SHARE

12. REMARKS: *Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.*

13. CERTIFICATION
I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL

TYPED OR PRINTED NAME AND TITLE: Floyd W. Jones, Director Social Services Finance

DATE REPORT SUBMITTED: May 25, 1977

TELEPHONE *(Area code, number and extension)*: 518 474-0147

269-101

STANDARD FORM 269 (7-76)
Prescribed by Office of Management and Budget
Cir. No. A-110

* U. S. GOVERNMENT PRINTING OFFICE: 1972—720-801

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
FINAL INVENTION STATEMENT AND CERTIFICATION
GRANT OR AWARD

DHEW GRANT OR AWARD NUMBER
11-P-90245

We hereby certify that, to the best of our knowledge and belief, all inventions are listed below which were conceived and/or first actually reduced to practice during the course of work under the above referenced DHEW grant or award for the period, July 1, 1975 (ORIGINAL EFFECTIVE DATE) through March 15, 1977 (DATE OF TERMINATION).

(If no inventions have been made under the grant or award, insert the word "None" under Title of Invention.)

NAME OF INVENTOR	TITLE OF INVENTOR	DATE REPORTED TO DHEW
	NONE	

Use Continuation Sheet if Necessary

Signature, in ink, is required in the space provided below, appropriate to the type of grant or award being supported.
SIGNATURE OF INSTITUTIONAL OFFICIAL REQUIRED IN ALL INSTANCES.

TYPE OF GRANT OR AWARD	SIGNATURES
1. FOR A RESEARCH GRANT X	Alfred Roberts (PRINCIPAL INVESTIGATOR OR PROJECT DIRECTOR)
2. FOR A HEALTH SERVICES GRANT	(DIRECTOR)
3. FOR TRAINING GRANT	(PROGRAM DIRECTOR)
4. FOR THE RESEARCH CAREER AWARD PROGRAM	(AWARDEE)
5. FOR A FELLOWSHIP OR DIRECT TRAINEESHIP AWARD _____	(a) (FELLOW OR TRAINEE) (b) (SPONSOR)
6. FOR OTHER TYPES OF GRANTS IDENTIFY TYPE: _____	(RESPONSIBLE PROGRAM OFFICIAL)

APPROVED:	SIGNATURE (INSTITUTION OFFICIAL) / TYPE NAME	TITLE	DATE
	NAME OF INSTITUTION	MAILING ADDRESS	

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